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Journal of Indian Health Psychology (JIHP) is a biannual refereed Journal devoted to interdisciplinary research with the objective of furthering an understanding of the scientific relationship between behavioural principles on one hand and health issues on the other. The Journal provides a forum to integrate the theoretical, empirical and application based knowledge in this area. The distinctive feature of the journal is to include a special section of the articles based on Indian perspectives of health psychology and behaviour. Dissemination of the knowledge among the profession and upcoming researchers will go a long way in benefitting the masses at large. Research carried out at individual, group and community level are welcome.

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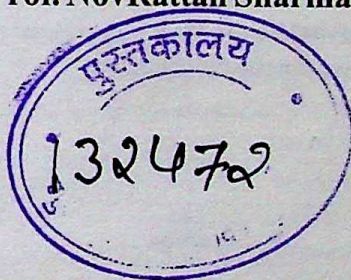
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Editors

Prof. Rajbir Singh

Prof. NovRattan Sharma



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EDITORIAL

In this issue of the *Journal of Indian Health Psychology* there are thirteen research articles, two short communications and a book review. This issue is devoted to diverse kind of empirical investigations in the field of health psychology.

The first article by Muni Ram and NovRattan Sharma assessed and compared the suicidal ideation among the students of professional and non-professionals courses. The authors have reported that professional students expressed more suicidal ideation as compared to non-professional and female students in both type of courses showed greater suicidal tendency as compared to males. They have further emphasized upon the need of psychological interventions especially for the students to deal effectively with the increasing suicide ideation. In the next article, Akbar Husain have made an attempt to develop a comprehensive scale of Health, Holistic Health Scale (HHS), with eight domains of health, namely, economic, emotional, environmental, mental, physical, social, societal, and spiritual. The following study enlisted in the current issue by Krishna Kumar Mishra examined the contribution of optimism as a determinant to predict health. Nazirul Hasnain, Mohammad Imran and Muhsina Lubaiba K M Asif compared Well-being and Self-esteem of children of working parents of Delhi and Kerala. Lakshya Rawat, Pragyendu, Mahesh K. Darolia and Soaham Bharti studied Identity Crisis and Self-monitoring in Indian adolescents. In the next article, Sarita Sood and Arti Bakhshi have reported significant contribution of each dimension of Psychological Capital in development of Subjective Vitality. Jaya A. T and Chandana D. Karathully in this article have examined the relation between dietary preferences and the inattention, hyperactivity and impulsivity in children between the ages of 5 to 15 years. Salma Kaneez assessed the adolescents' knowledge of life-style related chronic diseases and its association with their health habits and health behaviour /care. In the next article enlisted in this issue, Ranjana have found family environment as a significant predictor of the Big Five personality dimensions and emotional intelligence. The next article have examined Executive functioning in children with learning disabilities and concluded that verbal working memory is the most important neuropsychological correlate of learning disability. In the last article, Zeba Qamar have addressed a very sensitive issue of child abuse and

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aimed to study emotional-instability, emotional-regression and social-maladjustment of those girls who have experience sexually abuse during their childhood. This issue includes a short communication by Vedagiri Ganesan on Behaviour technology for effective management of gays, lesbians and queers. Another short communication by R. Santhanakrishnan also focused on Behaviour technology and found significant enhancement in the Emotional Intelligence of the industrial workers with the application of Behavior technology. We are thankful to all contributors for contribution of their articles in this issue.

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SUICIDAL IDEATION AMONG STUDENTS OF PROFESSIONAL AND NON-PROFESSIONAL COURSES: A HEALTH THREAT

Muni Ram* and NovRattan Sharma**

ABSTRACT

Suicidal ideation often occur as a response to a situation that the person views as overwhelming, such as social isolation, death of loved one, hopelessness, academic and parental pressure, serious physical illness, financial problem, guilt feeling, loving affair, alcohol consumption and negative life events. Suicidal ideation has become a threat to general health status of the public and there is a need to understand its spread. The present study was planned to assess and compare the suicidal ideation among the students of professional and non-professionals courses. The sample of the study involved 300 college students (150 professional and 150 non-professionals) between the age ranges of 16 to 24 years. The students were assessed with Suicidal Ideation Questionnaire (Reynolds, 1987). The data were analyzed by using statistics-mean, SD and t-test. The results showed that (i) Professional and non -professional group of students differ significantly on suicidal ideation. (ii). Male and female students of professional group differ significantly on suicidal ideation. (iii). Male and female students of non-professional group differ significantly on suicidal ideation. The educational institute needs to take appropriate psychological steps to deal effectively with the increasing suicide ideation among students.

Key Words: Social isolation, Suicidal ideation, Suicidal behaviour.

Health is a multi-dimensional concept many factors contribute to its outcome. Thinking of an individual directly affects the psycho-social health. Suicidal ideation is a first threatening sign of serious suicidal behavior. It is particularly defined as the domain of ideas and thoughts about suicide or death and serious self-injurious

* Research Scholar, Department of Psychology, Maharshi Dayanand University, Rohtak.

** Professor, Department of Psychology, Maharshi Dayanand University, Rohtak.

behavior. It consists of thoughts which are closely related to the conduct, planning, and outcome of suicidal ideation, particularly as the last relates to thoughts about the response of others. Researcher has focused on suicidal behavior as a distinct form of psychological disturbance and a domain of suicidal behaviour. There are lots of factors may contribute to suicidal ideation of an Adolescent, including daily hassle, personal and societal factor as well as the interaction amongst these variables. Furthermore, suicide or purposeful self-harm, an event considered as more of a cultural or social fact is recently recognized as a community health problem in most of the nations.

Individuals attempt to resolve the issue of identity versus role confusion throughout the period of teenage. Teenagers to reply the question "Who am I" in order to set up uniqueness in context to communal, sexual, philosophical as well as occupational realms. According to Lock and Steiner (1999) adolescents frequently face substantial strain in the diversity of circumstances because adolescents challenge to counterfeit the identity. For instance, the altering sexual roles of male and female may strengthen confusion in identity. In adding, ecological stresses i.e. stress in parents for educational attainment, relatives 'agility, drug accessibility and pressure of peer may steer to depression (Capuzzi, 1994). Suicides appear after pressure; intellectual irresponsibility and emotionless attachment act together and overcome capability of individuals to manage as well as to reason undoubtedly. Extra pressure associated to parents was reported significantly in adolescents who had committed suicide. Generally in adolescents, complaints related to mood disturbance are found (Archer and Slesinger, 1999).

According to literature, lack of parents/no availability, bad contact among members of family, family clashes, more expectation of parents regarding success as well as obvious family pathology are usually measured important hazardous aspects for suicide. Suicide ideation relates with psychosocial suffering, drugs consumption, pressure of family and unclear school objectives (Thompson, 1994).

Causative Factors for Suicide

Suicidal ideation often occur as a response to a situation that the person views as overwhelming, such as social-isolation, death of loved one, hopelessness, academic and parental pressure, serious physical illness, financial problem, guilt feeling, loving affair, alcohol consumption and negative life events. Juon, Nam and Ensminger (1994) analyze causative factors of suicidal ideation in 9886 high school Korean youngsters study revealed that students who reported feeling a soaring level of tension concerning scholistic achievement and higher education were more possibility to have severe feelings about suicide ideation than those students who did not face academic stress. Similarly, in Singapore, educational hurdles were also found to be one of the predictors of suicide behavior among a population of adolescent suicide attempters as well other factors. School troubles accounted for 11% of youths who attempted suicide in Singapore. In adding to

students putting enormous stress on themselves to do extremely well in school, they were also aware of the requirement to fulfill familial obligations and live up to the desires of parents and teachers. Taken together, experimental facts towards scholastic pressure and in particular academic expectations is contributing to suicidal behavior in youth especially in East Asia.

Toero, Negy Sawaguchi and Sotonyi (2001) found that there is positive correlation between academic pressure in school/colleges and suicidal ideation. It denotes that in exam time numerous suicidal cases are appeared and stress level of the students are also high at that time. In this age academic performance is highly valued for them and if they do not reach the level of their expectancy that could leads to suicidal ideation. Unhealthy surroundings in schools, i.e. stress for academicals achievement and related stress for Grade-twelve students in finding employment after completion of schooling, is associated with enhancement of alcohol consumption between youngsters (Coker and Borders, 2001; Kwon Hoo, 2002). The consumption of alcohol as well as new substances act as a threat factor in suicide ideation, which ultimately prompts the adolescent to self-injurious performances (Gilliland and James, 2001).

Suicide Ideation in Adolescents

During the adolescent period many changes also occurs like, cognitive, physical, biological and emotional. Due to these changes there are changes in role and responsibility as well. In order to manage these changes students have to face with problems and conflicts (Asari, 2002). In adolescents period, students are not able to adjust their self due to their changes creates stress and tension. If students face this stress and tension in early stages, it may lead them towards the mental pressure (Newman, 2005).

When the student is joining the college for first time then he has to leave his family and friends. He has to face a new and unknown challenging environment which is not easy for him. In this new environment there are many significant development issues for him. As compared to school, college life has more social and academic pressure. There are numbers of stressors identified in the students like too many assignments, lack of pocket money and competition with other students. These all above stressors leads a student's towards the suicide ideation. Students have poor relationship with other students, teachers, family members, inadequate resources and semester system in exam to perform academic performance disorganized the students and less able to cope up thus resulting in stress related problems. (Mishra and Mckean 2000; Polychronopoulou and Divaris, 2005; Erkutlu and Chafra, 2006).

Rational of the Study

Reynolds and waltz (1986) findings suggest that adolescents frequently find themselves under tremendous stress. Problems most often occur when stressors

at home, school, and with peers occur within a context of minimal social and emotional support. These problems are further exacerbated when there is a lack of coping strategies, or when behavioural deficits or dysfunctions exist. Furthermore, those adolescents are at greater risk for suicide when they are experiencing major negative life events, having a lot of "hassles", and have little social support. Realizing suicidal ideation as a health threat, present study was planned to assess the suicidal ideation among the students.

The main objectives of the study are:

1. To assess and compare the Suicidal ideation of male and female students of Professional and Non-Professional courses.
2. To assess and compare the Suicidal ideation of male and female students of Professional courses.
3. To assess and compare the Suicidal ideation of male and female students of Non-Professional and courses.

The proposed Hypotheses of the study are:

1. There would be no significant difference between students of Professional and Non- Professional courses at the level of suicidal ideation.
2. There would be no significant difference between male and female students of Professional courses at the level of suicidal ideation.
3. There would be no significant difference between male and female students of Non- Professional courses at the level of suicidal ideation.

METHOD

Sample

A total of 300 subjects (168 males & 132 females) participated in present study to fulfill the requirement. Participation of the subjects in the present study was voluntary and informed consents were obtained from all the subjects. All subjects were of the age between 16 to 24 years and from professional and non professional courses institutions. 150 students were selected from professional courses and 150 students were selected from Non-Professional courses institutions. The sample was selected on the basis of availability. Data were gathered from various districts of Haryana i.e. Hisar, Rohtak, Ambala and Panchkula.

Tools

Following tool was used for the purpose of data collection.

Suicidal Ideation Questionnaire: The scale for suicidal ideation was developed by William M. Reynolds (1987). The Suicide Ideation Questionnaire (SIQ) does provide a measure of the seriousness of suicidal thoughts in adolescents. The Senior High School Version of SIQ consists of 30 items, the

respondent rates the SIQ items on a 7-point scale which assesses the frequency with which the cognition occurs. This test takes five to ten minutes to complete. The SIQ is designed to provide a reliable and valid estimate for identify individual's current level of suicidal ideation or suicidal risk. The SIQ does provide probability estimates of risk for completed suicide or suicide attempts. Given the variability in individuals, personalities, self-control, motivations, numbers of stressors and family and support structures, subscribing a numerical probability for suicide is not a realistic possibility. The scale assesses the extent of suicidal thoughts and their characteristics as well as the subject's attitude towards them. SIQ has been found to psychometrically potent tool to assess suicidal ideation across the world.

Procedure: The data was collected in small group i.e. only 25 to 30 students participated in one session. The subjects were contacted personally in their respective educational institutions for data collection after obtaining permission from the institute authorities. At the first, the investigator approached the subjects in various institutions and a good rapport was established for creating congenial environment to make them comfortable and to extract authentic information from them. The selected subjects were requested to answer frankly and honestly as the information provided by them was to be kept confidential and would only be used for research purposes. When the subjects were comfortable and ready to answer then after obtaining consent of the subject to act as respondent, firstly following instructions were given: "you will be given one questionnaire in which there are some personal questions regarding your personal data and you have to respond on the basis of your preference. Please read questions carefully before filling the information. The questionnaire i.e. Suicidal Ideation Questionnaire (SIQ) will take five to ten minutes to complete and you have to fill it rapidly. Success of present work directly depends upon your valuable cooperation and sincerity". The test was administered by following instructions specified in the test manual.

Statistical Analysis

For analysis of the scores descriptive statistics (mean, SD), t-test were computed for the scores of the entire sample. The scores of these groups (professional/non-professional, male/female) were analyzed by computing mean, SD, and t -test statistics with the help of SPSS 16.0 version.

RESULT AND DISCUSSION

Suicidal ideation is considered as an important variable among male and female students of professional and non-professional courses. To see significance of mean difference on suicide, two groups (professional and non-professional) were formed and compared with each other to see the suicidal ideation level among students. In order to check the significance of mean difference, t- test was used.

Table 1: Mean, SD (Standard Deviation) and t-value of Suicidal Ideation among students for professional and non-professionals group.

TOTAL N= 300 <i>VARIABLE</i>	Group-I (professional, n=150)		Group-II (non-professional, n=150)		t- value
	<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>	
Suicidal Ideation	42.20	39.62	29.26	28.22	3.26**

**p<0.01

On suicide ideation, the mean score of professional subjects was found to be 42.20 and SD score was found 39.62, on the other hand the mean score of non professional group was 29.26 and SD 28.22. The present results indicated that professional group has more suicide tendency as compare to non professional group. The statistical analysis ($t = 3.26, p < .01$) also indicate that there is a significant difference between professional and non – professional group means. The professional students are showing significantly higher suicide tendencies. The proposed first hypothesis is rejected on the basis of present results. Zhang, Yu and Zhao (2012) conducting a study on medical professional and found that 24.5 percent of medical students have experienced suicidal ideation at one point of time. Agarwal, Rakesh and Chahar (2007) conducted a study on engineering students and found that in India students of engineering and management course are experiencing overload position, unoccupied and self-detachment. All these reports concluded that professional students have more adjustment problems in comparison to non-professional group. Probably the reason may be lack of social support, loneliness specific personality factors cumulative hardships and many more difficulties contributing to poor emotional adjustment of the professional students. The present results indicated that students of professional group have more suicide tendency as compare to non professional group. On the basis of results the first hypothesis is rejected. There is clear evidence that students of professional courses experienced more suicidal ideation as compared to non-professional students.

On the attainment of first objective, the researcher compared the suicidal ideation of male and female students of professional courses.

Table 2: Mean, SD (Standard Deviation) and t-value of suicidal ideation for male and female students in Professional group.

Total N=150 <i>VARIABLE</i>	Male, n=84		Female, n=66		t-value
	<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>	
Suicidal ideation	33.00	36.03	53.90	41.12	3.31**

**p<.01

On suicide ideation, the mean score of male subjects was found to be 33 and SD score was found 36.03 on the other hand the mean score of females' sample 53.9 and SD 41.12 respectively. The present results indicated that female have more suicidal tendency as compare to male students in professional group. On the basis of mean differences, female students of professional courses explored more suicidal ideation as compared to male students. Mean comparison on the basis of t- test also indicate that female students of professional courses have shown significantly higher suicide ideation scores. Nisbet (1996) conducted a study to assess whether a 'model of social support' can assist in lowering the suicidal rate in black females, however findings suggested that females had greater suicidal attempt as compare to males. Mazza and Reynolds (1998) conducted the longitudinal study to investigate the relationship of psychological and social-environmental factor with adolescent suicidal ideation in student. Findings indicate that daily hassles and negative life event for male and social support and depression for female were a significant factor related to suicidal ideation. In another current study by Akhtar and Alam (2015) revealed that there is no significant difference in suicidal ideation as far as gender is concerned. On the basis of present results the second hypothesis is rejected. There is clear evidence that female students of professional courses experienced more suicidal ideation as compared to male students.

The third and final objective of the study was to compare the male and female students of non- professional courses on suicide ideation.

Table 3: Mean, SD (Standard Deviation) and t-value of suicidal ideation for male and female students in Non-Professional group.

Total N=150	Male, n=85		Female, n=65		t-value
VARIABLE	Mean	SD	Mean	SD	
Suicidal ideation	20.9	26.01	40.2	27.3	4.3**

**p<.01

On suicide ideation, the mean score of male subjects was found to be 20.9 and SD score was found 26.01 on the other hand the mean score of females' sample 40.2 and SD 27.3 respectively. The present results indicated that female have more suicidal tendency as compare to male students in non-professional group also on the basis of mean differences. The statistical treatment to the data highlighted the significant mean differences in suicide ideation scores of male and female students of non- professional courses. Hyun, Karen, and Eun (2006) examined the role of different gender in suicide ideation. As a result of the multivariate analysis most important factors leading to suicide ideation in females were depression hostility, sexual direction, and self-respect. Fernando, Ostbye, Woods and Abeyagunawardana (2007) compared the prevalence of suicide ideation

and deliberate self-injury in youngsters' males and females on high school children using a self-report, anonymous questionnaire in the local language. Results concluded that females reported suicidal ideation at least once in their lifetime more frequently than males (12.1% vs. 6.5%). Furthermore, twenty-two (3.7%) females and 13 (3.5%) males reported that they had deliberately sought to harm themselves at least once in the 12 months preceding the survey. Sulaiman, Hassan, Sopian and Abdullah (2009) found in their study that females students experience stress differently compared to the male students. This may be because female students tend to be more emotional and sensitive toward what is happening in their surrounding". Skinner and McFaul (2012) in a longitudinal study published by the Canadian Medical Association Journal, which looks at suicides by boys and girls over a thirty year period (1980-2008), there has been a modest decline in suicide for boys aged 10-19 years and a slight rise for girls in the same age range. Girls have always attempted suicide more frequently than boys; however, there is reason to believe that girls are increasingly using more lethal means like hanging, when attempting suicide which could account for the increase in suicidal deaths. A survey conducted by a Mental health organization in 150 educational institutions in New Delhi found that 40% of students feel overwhelmed by exams. Another study conducted by a non-governmental organization with 850 students found that 57% were depressed and 9% had considered committing suicide as a result of academic stress (Maheshananda, Bera, Gore, Bhogale, Kulkarni, Thakur, 2012). On the basis of findings the third hypothesis is rejected. There is clear evidence that female students of non-professional courses experienced more suicidal ideation as compared to male students. In this way, all the three objectives are attained and the corresponding null hypotheses are rejected. The findings further emphasized that some immediate steps may be taken up in all the educational institutions otherwise it will be a very serious threat to general health of students.

CONCLUSION

Present paper focused on to assess and compare suicidal ideation among male and female students of professional and non professional courses. On the basis of present findings it may conclude that professional students expressed more suicidal ideation as compared to non-professional as well as female students in both type of courses shows greater suicidal tendency as compared to males.

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DEVELOPMENT OF HOLISTIC HEALTH SCALE

Akbar Husain*

ABSTRACT

A number of measures are available for the assessment of health and well-being. The present investigator has made an attempt to develop a construct that could assess more dimension of health in addition to the domain suggested by WHO, namely, physical, mental, social and spiritual. The Holistic Health Scale (HHS) comprised of 78 items with eight domains of health, namely, economic, emotional, environmental, mental, physical, social, societal, and spiritual. Cronbach coefficient Alpha of HHS was found to be 0.946. The operational definitions of the eight dimensions of holistic health are described here for a clear understanding of the model. The main objectives of the present study are:

- 1) To develop an objective measure for the assessment of holistic health.*
- 2) To determine the psychometric characteristic viz., reliability of the scale.*

The 80 items representing to the eight dimensions of health were subjected to CFA using the Structural Equation Modeling program AMOS 4.01. Fit indices for the 78 item model representing to the eight dimensions of HHS and overall indicated a good fit. In addition, internal consistency was found to be highly reliable for all the dimensions of HHS.

Keywords: Holistic health scale; Quality of human life; Structural equation and modeling program

Health is a determinant factor of the quality of human life. It is a critical component of well-being. A weakness in health easily leads problems in any other component of well-being. Human beings do not have only body and mind; but also have soul or spirit. We know that our heart has physical functions; but there is no scientific evidence to prove that it does not have any spiritual function. The soul probably resides in the heart or is attached to it. Soul is the inner dimensions of our being.

* Professor, Department of Psychology, Aligarh Muslim University, ALIGARH-202002.

Health is a multidimensional construct. The factors which influence health lie within the individual and externally in the society and environment in which an individual lives. An individual's health may be affected by a number of factors such as heredity, environment, lifestyle, social, socioeconomic, etc. The WHO definition of health introduces the concept of well-being. In the WHO definition, a state of physical, mental and social well-being is the major concern. The well-being of an individual can be assessed by means of objective and subjective components. The objective components relates well with the "standard of living" and "level of living", whereas the subjective component of well-being is referred as "quality of life."

Almost daily, the mass media such as the television and newspapers, and magazines, remind us the importance of maintaining holistic health. It is therefore, crucial to develop a measure for the assessment of holistic health and to understand the dimensions that are important in the health maintenance behavior.

In general, five aspects of health have been explored in the literature. They are: social, physical, mental, spiritual, and intellectual. However, the present study considers eight dimensions of health. No such measure is available to assess the holistic health.

Components of Holistic Health

All the components of health are important for the maintenance of holistic health. Holistic health includes all the efforts spent on achieving optimal physical, social, mental, spiritual, emotional, societal, economic and environmental aspects of health.

The development of the Holistic Health Scale (HHS) followed a preliminary step of reviewing the literature for relevant material regarding various concepts of health. The primary literature sources were in the fields of psychology and sociology. From this endeavour, the concepts of health were identified and theoretically described. The identified concepts of health are considered the dimensions of holistic health. The operational definitions of the eight dimensions of holistic health are described here for a clear understanding of the model.

Economic Health: It deals with financial burden of health care to an individual with special reference to quality care and costs of health services, health policy planning and implementation.

Emotional Health: This refers to the power of feelings and emotions, thoughts, and behaviors that keep a person healthy overall level. People who are emotionally healthy are in control of their thoughts, feelings and behaviors. This is essential to mental health. This is something that you feel and think in improving your health-related quality of life.

Environmental Health: WHO defined environmental health as "those aspects of human health and diseases that are determined by factors in the

environment? It also refers to the theory and practice of assessing and controlling factors in the environment that can potentially affect health." Environment health also affects the health and well-being of the broad physical, psychological, social and aesthetic environment which includes housing, urban development, land use and transport.

Mental Health: It has been considered as an important factor influencing individual's various behaviors, activities, well-being and performance. In recent years, mental health has been described in more positive terms not merely as the absence of mental illness. For the purpose of the development of holistic health scale, mental health can be defined as person's ability to cope life stresses, to make adequate adjustment, positive self-evaluation and maintain temperance.

Physical Health: This refers to the absence of illness or infirmity. With the physical exercises, the soul or spirit becomes strong and healthy. Exercise helps people to feel better physically and mentally. Among the factors unhealthy eating, lack of physical activity, excessive alcohol use, obesity, smoking are seen as the most important health threats.

Social Health: It characterizes when a person finds a balance between his life goals, values, belief system and relationship with others or to care meaningfully others. It is the ability to maintain social adjustment or to socially considerate behavior.

Societal Health: It may be defined as the ability to make adjustments to the society/community on the level of development. Societal health is determined by the prevailing health thinking in a society. In the present context, societal health we mean how much an individual is loaded with responsibilities to maintain and improve other's health in terms of healthy living.

Spiritual Health: It is related to the spirit or sacred matters. Human beings do not have only body, mind, and also have soul or spirit. The spiritual health depends on our success both in this world and hereafter as well. Spiritual health is an integral part of holistic health.

Previous Studies

Nazam (2013) used Holistic Health Scale (HHS) developed by Husain (2009) to measure holistic health of male and female teachers of Aligarh Muslim University (AMU). One hundred eighty teachers (90 female, 90 male teachers) were drawn from the different faculties. Main findings of the study were as follows: Male and female teachers did not differ significantly on seven dimensions of holistic health, namely, economic, emotional, environmental, mental, physical, social and societal and they did differ significantly on spiritual domain. Female teachers scored higher than male teachers, though not significantly on the overall scores obtained on HHS.

Nandal, Sharma and Yadava (2014) have found association between different dimensions of holistic health with different religious groups. In Hindu sample,

significant associations were not observed regarding the concerned variables. In Muslims group, significant positive association was found on societal health dimension. In Sikh group significant positive associations were observed on societal and spiritual health dimensions. On the other hand, the Christian groups showed significant positive association with emotional and physical health dimensions. However, the investigators have not observed the strong relationship between rituals and holistic health but emotional societal and spiritual health have been found to be associated positively and significantly.

The result of total group explains that the subjects express positive and significant associations on, economic, environmental societal health. In Hindu sample it seems that subject experience greater economic health. In Muslims group, significant positive associations can be observed on economic and physical health dimensions and negative but significant associations on emotional and environmental health. No significant associations was found in Sikh group. In the Christian group, significant positive association with physical, societal and spiritual health dimensions were observed.

Research Objectives

The main objectives of the present study are:

- 1) To develop an objective measure for the assessment of holistic health following the confirmatory factor analysis.
- 2) To determine the reliability of the scale.

METHOD

Participants and Procedure

Three hundred thirty post-graduate students of the Faculty of Education, University of Malaya participated in this study. Participants were 165 male and 165 female. They belonged to three ethnic groups, namely, Muslim-Malay, Indian Hindu, and Chinese Christian. The age range of the participants was from 25 to 35 years. Participants were administered the 80 items Holistic Health Scale (HHS).

Measure

Development of Holistic Health Scale Ninety items were initially generated by the investigator in the Postgraduate course titled *Instrument Design and Item Development* (No. PPGS 6322). The author of this paper and four teachers of the Faculty working in the discipline of Psychology and Physical Education evaluated these items and placed equal number of items i.e. 10 in the eight dimensions of health: Economic Health, Emotional Health, Environmental Health, Mental Health, Physical Health, Social Health, Societal Health, and Spiritual Health. Finally 80 items were retained. Out of 80 items, there are 25 negative items and the remaining 55 items are positive. Items representing to the eight dimensions of HHS are given below.

Economic Health: 12, 24, 26, 36, 43, 51, 53, 57, 63, 70

Emotional Health: 1, 22, 27, 38, 50, 61, 62, 68, 72, 76

Environmental Health: 6, 7, 9, 23, 25, 28, 49, 54, 65, 76

Mental Health: 13, 18, 31, 33, 40, 47, 60, 74, 77, 80

Physical Health: 10, 29, 32, 34, 37, 56, 66, 71, 73, 78

Social Health: 2, 8, 14, 15, 30, 39, 41, 45, 55, 79

Societal Health: 3, 16, 17, 20, 35, 44, 48, 52, 59, 69

Spiritual Health: 4, 5, 11, 19, 21, 42, 46, 58, 64, 75

Negative Items: 12, 13, 19, 21, 28, 30, 31, 33, 40, 45, 47, 50, 52, 54, 60, 61, 65, 66, 67, 68, 73, 76, 77, 79, 80. These items are to be scored in reverse direction.

The HHS comprised 80 items with a five point Likert scale. Cronbach coefficient Alpha of HHS was found to be 0.946. Cronbach coefficients Alpha for the economic health domain 0.61, emotional health domain 0.61, environmental health domain 0.65, mental health domain 0.74, physical health domain 0.78, social health domain 0.59, societal health domain 0.84 and spiritual health domain 0.75 were found to be highly reliable.

Data Analysis

The 80 items representing to the eight dimensions of health were subjected to CFA using the Structural Equation Modeling program AMOS 4.01. The internal consistency reliability of the scale was determined by Cronbach alpha. The SPSS 16.0 version was used to analyze the data.

RESULT AND DISCUSSION

Table 1: Indicating Descriptive Statistics

Mean	SD	N
287.12	39.96	330
Males		
Mean	SD	N
288.07	41.27	165
Females		
Mean	SD	N
286.16	38.70	165
Economic Health		
Mean	SD	N
46.94	7.56	330
Emotional Health		
Mean	SD	N
34.71	5.13	330
Environmental Health		

Mean	SD	N
36.06	6.22	330
Mental Health		
Mean	SD	N
34.79	5.56	330
Physical Health		
Mean	SD	N
35.71	5.89	330
Social Health		
Mean	SD	N
35.28	6.04	330
Societal Health		
Mean	SD	N
36.60	6.07	330
Spiritual Health		
Mean	SD	N
38.26	7.04	330

Table 2: Summary of Fit Index for Confirmatory Factor Analysis on Eight Dimensions of HHS

<i>Dimension of HHS</i>	<i>GFI</i>	<i>AGFI</i>	<i>NFI</i>	<i>TLI</i>	<i>CFI</i>	<i>IFI</i>	<i>RMSEA</i>	
EH	0.922	0.869	0.878	0.869	0.902	0.903	0.103	0.793
Emo H	0.950	0.921	0.745	0.788	0.835	0.841	0.061	0.617
En H	0.932	0.893	0.884	0.933	0.948	0.949	0.046	0.656
MH	0.952	0.924	0.825	0.859	0.890	0.893	0.063	0.684
PH	0.929	0.889	0.850	0.856	0.888	0.889	0.086	0.785
SH	0.967	0.948	0.912	0.954	0.965	0.965	0.043	0.594
Soc H	0.952	0.920	0.946	0.953	0.965	0.953	0.073	0.882
SH	0.939	0.905	0.914	0.922	0.940	0.940	0.079	0.750
GFI	-	GOODNESS OF FIT INDEX						
AGFI	-	ADJUSTED GOODNESS OF FIT INDEX						
NFI	-	NOUNED FIT INDEX						
TLI	-	TUBER LEUNIS INDEX						
CFI	-	COMFARATIVE FIT INDEX						
IFI	-	INCREMENTAL FIT INDEX						
RMSEA	-	ROOT MEAN SQUARE ERROR OF APPROXIMATION						

Author assessed goodness of fit with a variety of fit indices. Finch and West (1997) recommended scores below .90 indicate acceptable fit. Whereas Browne and Cudeck (1993) considered the root-mean-square error of approximation (RMSEA) on which values below .10 indicate adequate fit. Following these

criteria, two items (one representing to the economic health and one representing to the societal health) were first eliminated because they reduced model fit.

There was a tension between achieving the best model fit and including all the dimensions of holistic health scale. The model that appeared to best balance concerns regarding model fit and internal consistency comprised 60 items in the six dimensions of HHS and 9 items in the economic health and 9 items in the societal health dimensions of HHS. Fit indices for the 78 item model representing to the eight dimensions of HHS are presented in Table 1 and overall indicated a good fit. In addition, internal consistency was good for all the dimensions of HHS.

CONCLUSION

Health is one of the most important aspects of human development. Extensive empirical support need for the validation of this scale. The HHS may be considered as the beginning point for the overall assessment of individual health.

Author looks forward to finding out more from studies that may be associated with various dimensions of holistic health. The advantage of focusing on holistic health is that people can be motivated to enhance the attitude towards the maintenance of health and see the subsequent effects on holistic health that can be directly measured. By advancing the focus of research on holistic health, we will be in a better position to apply scientific rigor to the various domains of holistic health and to highlight findings that will be applicable to the general people.

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DISPOSITIONAL OPTIMISM AND HEALTH

Krishna Kumar Mishra*

ABSTRACT

Research conducted on the relationship of health with optimism is seen to be restricted only to the physical and psychological determinants at large. As world health organization define the health and emphasized the relevance of social well-being in health with physical and psychological well-being, there is a need to include social well-being as one of the indicators of health status and then calculate the effect of optimism on health of any individual. A study designed to fill this unseen gap in the literature. Males and females of 15 to 70 years age were included in the study. Hindi version of WHOQOL- Bref Questionnaire and Satisfaction with Life Scale (SWLS) were used to assess the overall health status of the respondents. Life Orientation Test - Revised (LOT - R) was used to assessing the level of optimism. Analysis of data shows that optimism is positively related with life satisfaction and quality of life and optimism has significant unique effect of life satisfaction and quality of life.

Keywords: Dispositional optimism, Heath related quality of life, and Life satisfaction.

Optimism is defined as a tendency to expect favorable outcomes. Research has demonstrated that there are individual differences in global optimism – that is, some individuals are more inclined than others to expect good things across a variety of life domains. A global, dispositional tendency to be optimistic will typically manifest itself in a variety of more specific beliefs tied to particular times, situations, or life domains; and over and above any dispositional tendency, optimistic or pessimistic beliefs may be activated or diminished by short-term factors (for example, people in happy or angry moods are more optimistic than people in fearful moods). Optimism and pessimism are generally conceptualized as opposite sides of a continuum. When this entry refers to “optimists” or “pessimists” that is used as shorthand for relative differences along such a continuum, not for qualitatively different types of people.

* Department of Humanities & Social Sciences, Indian Institute of Technology Kanpur, INDIA

Research on dispositional, global optimism helps paint a picture of the personality traits and outcomes typically associated with being an optimist. This research has shown that optimists tend to have somewhat higher levels of extraversion and self-esteem, and lower levels of neuroticism, stress, anxiety, and hopelessness. Optimism is associated with a number of favorable outcomes in various domains of physical health and psychological functioning. For example, optimism assessed prior to a stressful transition has been shown to predict fewer physical symptoms in patients and better immune system functioning during the transition. Optimism is also correlated with lower depression, fewer mood disturbances, and fewer negative interpersonal interactions. Optimism has been shown to predict less negative affect, depression, and stress during major life transitions.

RELATIONSHIP OF OPTIMISM WITH PHYSICAL AND PSYCHOLOGICAL WELL-BEING

Well-being is an essential component of mental health. Well-being reflects a favorable judgment of the quality of a person's life. Schweizer, Beck-Seyffer, & Schneider (1999) observe that optimism can influence an individual's sense of well-being. It is logical that an intimate relationship would exist between the nature of a person's expectations of the future and how the person would evaluate his or her own life. Strassle, McKee and Plant (1999) mentioned that optimism is positively correlated with "life satisfaction, positive physical and mental health, lower frequencies of mental disorders, and self-esteem" (p. 191). Avia (1997) suggested that positive emotions are essential to overall well-being, and that good mood, optimism and satisfaction with one's life are vital aspects of a healthy personality. Peterson (2000) refers optimism to be linked to good mood. In respect of the psychological or mental benefits, optimism has been found to buffer the effects of daily stressors on self-esteem and burnout in woman executives (Fry, 1995).

Burke, Joyner, Czech, & Wilson (2000) reported that optimists, as opposed to pessimists, display better physical health. Peterson (2000) cited several studies that report positive correlation between optimism and good health. In terms of physical benefits, optimism as a personality attribute has been found to be a significant mediator or moderator of stress levels. Scheier and Carver (1987) proposed that the causal link between optimism and physical health or well-being may be due to the use of more effective coping strategies by optimists when dealing with stress. Other researchers have found that chronically stressed subjects are less optimistic than controls and that both optimism and pessimism are "influenced by environmental circumstances and life experiences" (Robinson-Whelan, Kim, MacCallum, & Kiecolt-Glaser, 1997, p. 1351). In summary, it is evident that empirical research strongly supports the proposition that optimism

is positively correlated with physical and psychological well-being. The empirical evidence is rapidly accumulating and different areas of human functioning are constantly being investigated in so far as the benefits of optimism and other resistance resources are concerned.

The main focus of present study is to examine the contribution of optimism as determinant to predict health status of an individual. Specifically its influence on social domain of health. Although it has been studied earlier that optimism does have significant association with physical and psychological indicators of health but its interaction with social indicators is less unexplored. In the present study we tried to calculate the effect of optimism on social indicators along with physical and psychological ones.

METHOD

The basic idea to conduct the present study was to assess social well-being of an individual along with physical and psychological well-being. To assess the overall health perception health related quality of life and feeling of satisfaction with life of an individual were assessed. Quality of life of an individual was operationalized as defined by World Health Organization (1995). According to this definition QOL is individuals' perception of their position in life in the context of culture and value system in which they live, and in relation to their goals, expectations, standards, and concerns. At the individual level QOL is a broad-ranging concept incorporating one's physical health, psychological states, level of independence, social relationships, personal beliefs, and the salient features of the environment. Feeling of satisfaction with his/her life was operationalized with the definition given by Shin and Johnson (1978). They defined life satisfaction as "global assessment of one's life quality according to his/her chosen criteria" (p. 477).

Sample

The present study was carried out with 426 participants drawn from the urban and rural settings of Varanasi. Male ($N = 212$) and female ($N = 214$) participants, aged 15 to 70, were included in the present study. The total sample consists of 208 participants from urban and 218 participants from rural settings. A quasi random sampling procedure was used to select the participants for the present study.

Measures

In the present study Hindi version of World Health Organization Quality of Life Questionnaire and back translated version of Satisfaction with Life Scale was used to assess health perception of the participants. Translated Life Orientation Test - Revised was used to assess the level of optimism of the participants.

World Health Organization Quality of Life Hindi version (WHOQOL-BREF) Questionnaire: The Hindi version of the scale used in this study was developed by Saxena, Chandiramani, and Bhargava (1998). This scale contains 26 items,

which measure four domains of QOL, namely physical health, psychological states, social relationships, and environment. Out of 26 items of the scale, only 24 items are scored. Items 1 and 2 are used as fillers, and not scored. The reliability ($r =$ Cronbach's Alfa) of this scale was calculated and it ranges from .59 to .85. Confirmatory factor analysis (CFI) revealed a very high validity index of physical health (0.957), psychological states (0.982), social relationships (0.972) and environment (0.922) domains.

Satisfaction with Life Scale (SWLS): This scale was developed by Diener, Emmons, Larsen and Griffin (1985) to measure the life satisfaction of an individual. The scale contains 5 items that assess satisfaction with life as a whole. This scale was given to participants to know how satisfied they were with their life. All 5 items are keyed in positive direction. The inter-item correlations for the five items were: 0.81, 0.63, 0.61, 0.75, and 0.66.

Life Orientation Test - Revised (LOT-R): This test was developed by Scheier, Carver and Bridges (1994). The test measures a respondent's degree of optimism or pessimism. The LOT-R is a short instrument consisting of 10 items. Only 6 of the 10 items are used to derive an optimism score. The remaining 4 items, (numbers 2, 5, 6 and 8) are filler items. Scheier et al. (1994) report that item-scale correlations range from .43 to .63. Cronbach's alpha for all six items was .78, reflecting an acceptable level of internal consistency.

Besides collecting data with above mentioned scale, information regarding the participant's age, residence, mobility, socio-economic status etc. were also obtained.

Procedure

Each participant was informed about the study, and consent for participation in the study was taken. The researcher was individually present throughout the session to make necessary clarification in case there were confusions and queries from the participants. The scales addressed the issues related to people's life and their satisfaction with it. These issues are prone to encourage social desirability, because participants are emotionally involved with them. Though it was difficult, sincere attempts were made to control this factor to the maximum possible extent. To do this the researcher established rapport with the participants. They were assured of the confidentiality of their responses. They were also told that their names will not be revealed to anyone at any stage of the study.

After the data collection was over, scoring of the responses was done according to the given coding procedure and data files were prepared for analysis. Gender, age, and socio-economic status of the respondents were finalized as variables of interest for the current analysis.

RESULT AND DISCUSSION

Analyses were designed to calculate the descriptive nature of data and to examine the relationships among optimism, life satisfaction and QOL measures.

Further the role of optimism in life satisfaction and different domains of QOL was also examined.

Means, SD and product moment correlation were computed to understand the relationships among optimism, life satisfaction, different domains of QOL. The correlation coefficient among these variables with regard to total sample is present in Table 1.

Table 1: Descriptive statistics and Correlations among Optimism, Life satisfaction and QOL for total sample

Variables	Mean	SD	Optimism	PH	PS	SR	En
LS	23.34	5.94	.146**	.148**	.395**	.232**	.299**
Optimism	21.02	3.56		.188**	.216**	.246**	.025
PH	14.88	2.44			.353**	.158**	.286**
PS	14.60	2.61				.453**	.463**
SR	9.85	2.63					.310**
En	14.20	2.30					

Note: Abbreviations (LS = life satisfaction, PH = physical health, PS = psychological states, SR= social relationships and En = environment, OQOL = overall quality of life)

* $p < .05$, ** $p < .01$,

Table 1 shows that optimism is positively correlated with life satisfaction and all domains of QOL namely, physical health, psychological states, social relationships and environment. Optimism is positively related with physical health, psychological states, and social relationships domains not with environment domain of QOL. Domains of QOL are also found significantly inter-correlated.

Table 2 presents the outcomes of hierarchical regression analysis of socio-demographic factors and optimism for life satisfaction measure.

Table 2: Results of Hierarchical regression analysis for predicting satisfaction with life from optimism (N = 426)

Predictors	Satisfaction with life	
	Model 1	Model 2
Gender	.031	.043
Age	.107*	.117*
Socio-economic status	.117*	.097*
Optimism		.121**
R	.149*	.190*
	.022	.036
R ²		.014
df 1 & 2	3, 422	1, 421
F	3.18*	6.06*

Note: Gender was entered as dummy variables. * $p < .05$, ** $p < .01$

For the hierarchical regression examining predictors of life satisfaction (see Table 2), analysis revealed that R was not significantly different from zero at the end of the first step. After step two, with all predictors in the equation, R was significant ($F 1, 421 = 6.06, p < .05$). After the first step R^2 change was not significant but two socio-demographic measures (age and socio-economic status) were significantly contributing to R . After step two R^2 change was significant with optimism and significantly adding to the total variance in prediction of SWL. The overall model is predicting a significant effect of dispositional optimism on satisfaction with life ($F = 3.93, p < .01$) and explaining 2.7% of variance (optimism added 1.2% above the control variable, $p < .05$). Result indicated that those who displayed higher level of optimism have higher level of satisfaction ($\hat{a} = 0.121, p < .05$).

Table 3 presents the outcomes of hierarchical analysis of socio-demographic factors and optimism for different domains of QOL measure.

Table 3: Results of Hierarchical regression analysis for predicting different domains of QOL (N = 426)

Predictors	Physical Health		Psychological States		Social Relationships		Environment	
	Model 1 (β)	Model 2 (β)	Model 1 (β)	Model 2 (β)	Model 1 (β)	Model 2 (β)	Model 1 (β)	Model 2 (β)
Gender	.171**	.189**	.087	.104*	.052	.035	.050	.047
Age	.041	.056	.083	.069	.064	.050	.033	.030
SES	.102*	.069	.212**	.183**	.271**	.246**	.256**	.261**
Optimism		.192**		.172**		.176**		.034
R	.194**	.270**	.248**	.299**	.295**	.341**	.255**	.259
R ²	.038	.073	.062	.090	.087	.116	.065	.067
R ²		.035		.028		.029		.002
df 1 & 2				3,422 & 1, 421				
F	5.51**	15.90**	9.24**	12.97**	13.43**	13.96**	9.76**	.490

Note: Gender was entered as dummy variables. * $p < .05$, ** $p < .01$

For the hierarchical regression examining predictors of different domains of QOL (see Table 3), analysis revealed that R was significantly different from zero at the end of each step for physical health, psychological states and social relationship domains, not for environment domain. After step two, with all predictors in the equation, R was significant for physical health ($F 1, 421 = 15.90, p < .01$), psychological states ($F 1, 421 = 12.97, p < .01$), and social relationship ($F 1, 421 = 13.96, p < .01$) domains. After the first step R^2 change was significant with two socio-demographic measures (socio-economic status for all domains and gender for physical health domain) and significantly contributing to R . After step two R^2 change was significant with optimism and significantly adding to the total variance in the prediction of overall QOL. The overall model

is predicting a significant effect of optimism on physical health ($F= 8.25, p< .01$) and explaining 7.3% of variance (optimism added 3.5% above the control variable, $p< .05$), on psychological states ($F= 10.37, p< .01$) and explaining 9.0% of variance (optimism added 2.8% above the control variable, $p< .05$), and on social relationship domain ($F= 13.87, p< .01$) and explaining 11.06% of variance (optimism added 2.9% above the control variable, $p< .05$). Result indicated that those who displayed higher level of optimism have better perception of physical health ($\beta = 0.192, p< .01$), psychological states ($\beta = 0.172, p< .01$), and social relationship ($\beta = 0.176, p< .01$) domains. On the other hand, the overall model is predicting a significant effect of optimism on environment domain ($F= 8.25, p< .01$) and explaining 6.7% of variance where optimism added only 0.02 % above the control variable, $p< .05$ which is insignificant. Result also indicated that displaying higher level of optimism does not contribute to the perception about environment domain ($\beta = 0.034, p> .05$) β

The present study was aimed to ascertain the role of optimism in health of an individual, including their social well-being. Analyses revealed that optimism was positively correlated with life satisfaction and physical health, psychological states, and social relationship domains of QOL. No significant association between optimism and environment domain was found. Hierarchical regression analysis showed that age was significantly contributing only for life satisfaction of total sample and socio-economic status have significant contribution to both criterion variables (life satisfaction and QOL). It also seems that, after controlling all the demographical variables, optimism significantly contributes to the total variance for both criterions (life satisfaction and QOL).

Findings of the present study can be explained with the help of relevant studies carried out in different places. The positive effect of optimism has been attributed to the strategies that optimists use to cope with stress (Carver, Pozo, Harris et al., 1993; Edgar, Remmer, Rosberger, & Fourmire, 2000; Epping-Jordan, Compas, Osowiecki et al., 1999). Studies indicate that optimists generally used acceptance and active coping strategies (e.g., appraisal). Lipkus et al. (1993) indicate that optimists believe that negative events are less likely to occur in the near future, may serve a vital function. By doing so, optimists tend to engage in activities, which will increase their chances of experiencing positive outcomes. Scheier and Carver (1987) reported that optimists were more likely to use active (problem-focused) coping strategies, especially those who felt that the stressful situation was potentially controllable. In situations where problem-focused coping is not possible, optimists tend to use adaptive emotion-focused strategies, such as acceptance, humor, and positive reframing of the situation (Scheier et al., 1994). Optimists then differ from pessimists in their stable coping tendencies and in the kinds of coping responses that they spontaneously generate when given hypothetical coping situations (Scheier et al., 1985). McKenna (1993) reported

that a "positive orientation to events can result in greater effort and persistence with resulting greater success" (p.47).

Schweizer et al. (1999) argued that optimism can influence an individual's sense of well-being. A relationship can be predicted between the nature of a person's future expectations and his/her evaluation of own life. In terms of physical benefits, optimism as a personality attribute has been found to be a significant mediator or moderator of stress levels. Optimism has been reported to "moderate the deleterious effects of daily hassles on physical health (Fry, 1995). Scheier and Carver (1987) propose that the causal link between optimism and physical health or well-being may be due to the use of more effective coping strategies by optimists when dealing with stress. Other researchers have found that chronically stressed subjects are less optimistic than controls and that both optimism and pessimism are "influenced by environmental circumstances and life experiences" (Robinson-Whelan, et al., 1997, p. 1351).

When studied with optimism, life satisfaction has been found to correlate positively (Cummins & Nistico, 2002; Uskul & Greenglass, 2005). Chang, Maydeu-Olivares, and D'Zurilla (1997) found optimism and pessimism were predictors of individual difference in life satisfaction. While studying optimism/age association, Isaacowitz (2005) reported that although older people reported higher dispositional optimism scores, there was no age X optimism interaction predictive of depression or life satisfaction, and that the dispositional optimism/age differential was eliminated when covariates were controlled. Scheier and Carver (1985) reported that dispositional optimism was associated with lower levels of physical symptoms than was pessimism. In a review of literature studying physiological associations with optimism, many of which were longitudinal studies, Peterson and Bossio (2002) indicated that most relevant studies report a .20 to .30 correlation coefficient between optimism and good health. Scheier et al. (1990) reported that optimists are more likely to report feeling rested after sleeping and less likely than pessimists to report early morning awakenings. This may relate to optimism's association with reduced anxiety reported by Scheier, Carver, and Bridges (1994).

Part of the details of how optimism affects physical health can be explained by its influence on behavior. Steptoe, Wright, Kunz-Ebrecht, and Iliffe (2006: 17) used separate and combined optimism/pessimism scores in a study of 128 men and women between 65 and 80 years of age. They reported that optimism was positively related to self-reported health status independent of healthy behaviors, and that physical health status was associated with optimism independent of social demographic, clinical condition, negative affect or body mass, but that the effect was "attenuated when health behaviors were taken into account".

Research indicates that perceived support is associated with several of the same processes as global optimism, including adaptive coping, favorable expectancies, and positive affect (Brissette, Scheier, & Carver, 2002). Recently, several studies have provided more direct support for a link between optimism and perceived support. Optimism has been associated with perceived support among air crash rescue workers, bereaved men, romantic couples, and students transitioning to college. It appears that, if global optimism is a general tendency to expect good things, perceived support is a more specific manifestation of optimism in which one expects a particular good thing (social support) in a particular context (close relationships) (Assad, Donnellan, & Cogner, 2007; Srivastava, MaGonigal, Richard, Butler, & Gross, 2006).

Regression analysis also showed that age was significantly predicting the life satisfaction and socio-economic status was significantly contributing to the QOL of the respondents. Researches regarding the role of age in optimism indicated that determinants and mechanisms of happiness or life satisfaction like income (Clark, Frijters, & Shield, 2008; Easterlin, 2001), social support (Haller & Hadler, 2006), adaptation processes (Frederick & Loewenstein, 1999), and the balance between aspiration and attainments (Plagnol & Easterlin, 2008) can explain the relationship of age with SWB.

Analysis also indicated significant correlation between socio-economic status and indicators of health. Numerous studies have documented that lower SES is associated with poorer health status (Anderson & Armstead, 1995; Marmot, Kogevinas, & Elston, 1987; Williams & Collins, 1995). Lower SES is linked to multiple types of health outcomes, including higher rates of disease-specific morbidity and mortality (Adler et al., 1994; Marmot et al., 1987), poorer physiological indicators of health (Kubzansky, Berkman, Glass, & Seeman, 1998; Seeman & McEwen, 1996), and less adaptive psychological characteristics (Cohen, Kaplan, & Salonen, 1999; Taylor & Repetti, 1997). The findings of the present study provide significant evidence in this respect, and they go with the findings of other studies.

Furthermore, low SES individuals find their relationships less useful in coping with stress than high SES individuals (House et al., 1988; Liem & Liem, 1978). Some studies suggest a positive relationship between people's SES or income status and psychological well-being or life satisfaction (Dohrenwerd & Dohrenwerd, 1969; Douhitt, Macdonald, & Mullis, 1992; Ying, 1992). These findings were also reported in several studies conducted in western European countries and also in U.S.A. The association between SES and health follows a common pattern (Hemingway, Nicholson, & Marmot, 1997; Marmot, Smith, Stanford et al., 1991), the lower the socioeconomic status the poorer the health. Similar results have been obtained from different countries in respect to cultural background or economic growth (Nicholson, Bobak, Murphy, Rose, & Marmot,

2005; Thumboo, Fong, & Machine et al., 2003). Pappa, Kontodimopolous, Papadopolous and Niakas (2009) studied the impact of SES on health of Greek people of 18+ age and results showed that females and older people were associated with impaired HRQOL. Disadvantaged SES i. e. primary education and low total household income was related to important decline in HRQOL and a similar relation was identified among men and women.

Results of the present study also indicated significant association between gender and optimism. Studies conducted on this issue reports mixed findings. Scheier, Carver and Bridges (1994, p. 1075) found "differences in correlation between men and women to be negligible". Shukla (2010) conducted a study to assess the level of optimism of male and female students belonging to two different settings. Results revealed that male students have higher level of optimism than female students. Pradhan, Samal and kumar (2008) had compared the level of optimism of 30 HIV infected and 30 healthy people. They found that male participants from both groups (HIV infected and healthy) have higher level of optimism than female participants. Even in the absence of systematic gender difference and in the levels of dispositional optimism and pessimism, Chang (1998) and R  ikk  nen, Matthews, Flory, Owen and Gump (1999) argued that they may exist in the developmental paths.

CONCLUSION

It may be concluded from the results that, SWB, QOL, and optimism are positively correlated with each other. People with higher level of optimism experience more life satisfaction and better QOL than people of lower level of optimism. Older people are more satisfied with their life than adults and younger ones, and respondents from high socio-economic status have higher life satisfaction and report better QOL than those from middle and low socio-economic status. Life-span developmental psychologists recognize adulthood as a time when changes take place in important psychological processes. For example, according to socioemotional selectivity theory (Carstensen, 1992; Carstensen, Isaacowitz, & Charles, 1999), when endings are made salient to individuals, they reorganize their social goals and prioritize emotionally salient goals over other ones. Getting older is the strongest cue that time is finite and that the most important ending is approaching. This theory suggests that individuals may become more optimistic with age, insofar as they are proactively regulating their socioemotional world.

Therefore, the complex of psychological processes surrounding emotional experience and well-being may change across life-span. Optimism has been a widely studied predictor of individual differences in affect (Scheier & Carver, 1993; Seligman, 1990). It seems that results obtained from the present study supports the cognitive models of affectivity which describes optimism as a predictor of well-being due to the habitual frames of processing information have ramifications for affect (Beck, 1967).

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WELL-BEING AND SELF-ESTEEM OF CHILDREN OF WORKING PARENTS: A CROSS-CULTURAL STUDY OF DELHI AND KERALA

Nazirul Hasnain*, Mohammad Imran** and
Muhsina Lubaiba K M Asif***

ABSTRACT

This study compared the well-being and self-esteem of children in Delhi and Kerala, which were considered individualistic and collectivistic cultures respectively. For this purpose a four group design was used, which comprised 120 children aged between 10 to 14 years. Out of the total, 60 children were taken from Delhi, wherein 30 were from families whose both parents were working, and 30 whose single parent was working. Similarly, 60 children were taken from Kerala, wherein 30 were from families whose both parents were working, and 30 whose one parent was working. They were administered the PGI General Well-being Measure of Verma and Verma and the Coopersmith Self-Esteem Inventory (School form). Results of t-test showed that the children of Kerala whose both parents were working scored significantly higher on well-being than the corresponding group of children of Delhi. Further, the group of children of Kerala whose only parent was working also scored significantly higher on well-being than the corresponding group of children of Delhi. Within Kerala, but not within Delhi, the well-being scores of children whose both parents were working scored significantly higher, than children whose one parent was working. Further, children of Kerala whose both parents were working scored significantly higher than the corresponding group of children of Delhi. However, the difference between the self-esteem of children of Kerala and Delhi whose one parent was working was found

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- * Professor, Department of Psychology, Jamia Millia Islamia, New Delhi.
** Ph.D. Scholar, Jamia Millia Islamia, Jamia Millia Islamia, New Delhi.
*** M.A. (Applied Psychology), Jamia Millia Islamia, New Delhi.

non-significant. Also, within Kerala, the self-esteem scores of children whose both parents were working were significantly higher, than the group of children whose one parent was working. This difference between groups of Delhi was not significant. Overall the results of this study indicate that the collectivistic cultural context of Kerala added with higher family incomes may facilitate the wellbeing and self-esteem more than the individualistic culture of Delhi.

Keywords: Well-being, Self-esteem, Children, Kerala, Delhi, Culture, Individualistic, and Collectivistic.

The momentous role of parents and caregivers in childrens' healthy upbringing cannot be understated. Right from conception to adulthood, and till the time children attain independence, parents and family remain an essential source of nourishment, nurturance and knowledge for them. It's not surprising then that parental behaviors have been found to affect several facets of childrens' psychological make-up and adjustment (Steinberg, Mounts, Lamborn & Dornbusch, 1991) including self-esteem (Buri, 1989), self-perception (Klein, O'bryant & Hopkins, 1996), well-being (Shucksmith, Hendry & Glendinning, 1995), school adjustment (Bronstein et al., 1996), and academic performance (Dornbusch, Ritter, Leiderman, Roberts & Fraleigh, 1987; Turner, Chandler & Heffer, 2009). What is more is that involvement of both parents in rearing has been associated with many positive outcomes for children, such as academic achievement, psychological adjustment, positive self-concept and social competence (Maccoby & Martin, 1983; Rollins & Thomas, 1979).

Drawing from various theoretical perspectives, Umberson (1992) affirmed that the parent-child tie is a strong and unique source of social attachment and solidarity for both children and their parents. Naturally, it is then reasonable to expect that such a close relation may affect the well-being of children and their parents by meeting each others' psychological needs such as those of nurturance, interaction and affiliation. Knoester (2003) has explained that the well-being of children affects parents' well-being through feelings of empathy; for one because parents vicariously experience their children's joys and sorrows and because childrens' successes and failures are believed to reflect on parents' performance.

However, this gratifying socio-emotional mutualism between parents and children may be compromised when parents are not able to spend quality time with their young ones. Given today's high-pressure work environments, parents may experience greater work-related stress, spend late hours in the workplace, and may even bring work home, which might consume the time that otherwise would have been available for nurturing the relationships with their children. As a consequence, parents' may not come to know of their childrens' everyday experiences, activities and whereabouts. Further, work-related stresses and/or the frustrations arising out of not being able to meet their family's needs because of

overwork, might be displaced on family members including children, and manifest in the form of outbursts of negative emotions, irritability and impatience at home. Thus, a warm, nurturing and positive home environment may become unconducive and hostile to healthy development of children and their well-being.

The effects of parents' employment on childrens' well-being and family have been explored by several studies. High work pressure has been found to result in greater feelings of overload for parents, increased conflicts between adolescent children and parents, and lower levels of well-being for both parents and children (Crouter, Bumpus, Maguire & McHale, 1999). Also, mothers in particular, have been found to withdraw from their preschool age children on the days they experience overload or interpersonal stress at the workplace (Baumrind, 1989). The effects of parents' workplace experiences on children seem unavoidable.

How many hours parents work in a day, as such, has not been associated with behavioral problems among children but the number of transitions between parents' employment and unemployment have been related to increased anxiousness and depressed behaviors among children (Kalil, Dunifon & Danziger, 2001). In addition, Strazdins et. al. (2004) investigated the effect of parents' employment (whether one or both worked) and working hours (standard or non-standard) on children. They found that in about three quarters of families where one of the parents worked during non-standard times regularly, child difficulties were greater compared to families where parents worked only during standard times. At the same time, parental work, in general, has been found to benefit low income children via provision of role models, and stabilization of family routines (Wilson, 1996). Parents' odd working hours and employment instability might be detrimental to children.

Maternal employment in particular, has been linked with positive outcomes for children during middle-childhood (Menaghan, Jekielek, Mott & Cooksey, 1998). Chase-Lansdale et. al. (2003) found that mothers' taking up jobs was related to improvements in mental health of adolescents, while mothers' employment stability was related to decreases in the adolescents' externalizing behaviors. On the other hand, mother's job losses were associated with increased behavioral problems in adolescents.

Overall, it appears that whether one or both parents work, the impact on childrens' well-being is not very much. Harvey (1999) found the effect of parental employment on childrens' development to vary by age, but such effects, whether negative or positive, were inconsistent.

A considerable body of research devoted to the relationship between parental behaviors and childrens' self-esteem has uncovered several predictors and correlates of childrens' self-esteem. Kawash, Kerr and Clewes (1985), have suggested that variation in childrens' self-esteem can be attributed to differences

in parental behaviors such as parental acceptance, discipline and autonomy. Also, parental support, autonomy, control and participation have been found to be significantly correlated with adolescents' self-esteem (Gecas & Sefff, 1990). Coppersmith (1967) based on his studies on pre-adolescent children put forward three antecedents of childrens' self-esteem, namely, total acceptance of children, enforced and defined limits of, and latitude for individual action. Among adolescents, parental support and parental willingness to grant autonomy and freedom to children has been related with high self-esteem of children (Marks, 1999). Further, a linear relationship was found by Coppersmith (1981) between adolescents' perception of parental warmth/acceptance, and their self-esteem. In general, it seems that if children share a good relationship with their parents they will experience higher self-esteem (Sui-Chu & Esther Ho, 1996).

Evidence shows that while some parental behaviors are conducive to childrens' self-esteem, others are detrimental. For instance, parental behaviors characterized by warmth, responsiveness and provision of reasonable expectations are associated with childrens' positive feelings about themselves, while those characterized by corrosiveness instill a sense of insecurity among children (Baumrind, 1971). Similarly, Hill & Frank (1980) found that parental acceptance was linked with positive self-esteem, whereas parental rejection with negative self-esteem among children. In addition, some extreme parent-child relationship scenarios portend regretful outcomes for childrens' self-esteem. For example, it has been shown that adolescents who find themselves under excessive pressure to perform at school are likely to have low self-esteem (Erikson, 1963), as are children who are abused by their parents (Covington, 1989). It seems that positive parental behaviors nourish, while negative behaviors emaciate childrens' psyche.

Studies have also investigated the effects of mothers' attributes on childrens' self-esteem. Behamdouni (1993) found mother's acceptance to be the most powerful predictor of children's self-esteem in their study. Higher levels of self-esteem have also been obtained among children whose mothers' are empathetic, genuine and have positive regard for children than mothers who do not have these qualities (Moore & Driscoll, 1997). Moreover, the degree of democracy in maternal behavior has been found to have a positive association with childrens' general self-esteem, academic self-esteem, and the likelihood of higher achievement (Frey & Carlock, 1987). These studies emphasize the impact of maternal behaviors on childrens' self-esteem.

So far as the gender specific effects of parental behaviors on boys and girls is concerned, mothers' permissiveness has been associated with high self-esteem of daughters, whereas fathers' permissiveness has been linked to high self-esteem of both sons and daughters (Mecca, Smelser & Vasconcellos, 1989). Further, adolescent boys with high self-esteem have been shown to have parents who are democratic, but are not as permissive as those of boys with low self-esteem

(Baumrind, 1975). Also, parental acceptance has been found to correlate negatively with parent-child disagreements, but only for girls (Hill & Holmbeck, 1987).

Parental behaviors may not only affect childrens' esteem directly, but also indirectly, because parents may serve as imitable role models for their children. Hilgard et. al. (1976) reported that adolescents, who had high self-esteem, also had parents who had high self-esteem. They reasoned that adolescents who identify with their parents may strive to model their personalities and behaviors after their parents. Thus, adolescents exhibiting high or low self-esteem may have identified with, and modeled their behavior after parents who had high or low self-esteem respectively.

It appears that cultural factors too can affect the childrens' self-esteem. Bhattie et. al. (1989) compared the self-image, ego strength, self-esteem and psychological well-being of normal group of adolescents from India to a group of adolescents from USA, Ireland, and Australia. The results revealed that the self-esteem or ego strength of American and Australian adolescents was higher than that of Indian and Irish adolescents. Further, there seem to be intracultural differences even within Western societies as to how parental behaviors are associated with children's self-esteem. For example, Erikson (1963) found that while some parental behaviors were significantly related with self-esteem of US adolescents, same behaviors were not related with self-esteem of German adolescents. Hence, cultural factors may too moderate the effects of parental behaviors on childrens' self-esteem.

Moreover, it seems that self-esteem and well-being go hand in glove to a quite an extent. Diener and Diener (1995) obtained a correlation of .47 between self-esteem and life-satisfaction in their study comprising 13,118 college students taken from 31 nationalities across the world. Furthermore, Paradise and Kernis (2002) reported that high self-esteem was related with higher well-being than with low self-esteem. Similarly, Schimmack and Diener (2003) found explicit self-esteem to be a significant predictor of subjective well-being. Thus, it is possible that self-esteem and well-being may influence each other and / or there may be some common factors which have an effect on both self-esteem and well-being.

The importance of child-rearing practices and involvement of both parents in child-rearing for healthy development of children has been empirically confirmed time and again. As discussed earlier, childrens' self-esteem may differ between cultures, as well as within cultures. Also, since well-being has been found to be closely associated with self-esteem, it too may differ not only between cultures, but within cultures as well. Since India is home to a great cultural diversity it is likely that self-esteem and well-being of children are not same across its different regions. At the same time, it needs to be seen as to how the changing landscape of family dynamics and parental employment owing to rapid urbanization affects childrens' well-being and self-esteem against the backdrop of cultural dissimilarity.

This study made an effort in this direction by assessing the variables under consideration in the states of Delhi and Kerala.

The state of Delhi with its heterogeneous, open and individualized society and the state of Kerala with its homogeneous, closed, collective and traditional socio-cultural values and lifestyle are two distinct sub-cultures within India. Consideration of these two sub-cultures seemed apt for this study, which assessed the relation of culture and parental employment with childrens' self-esteem and well-being. Also, since studies comparing childrens' self-esteem and well-being in relation to parents work status across sub-cultures are scarce in available literature, this study attempted to explore this domain.

METHOD

Participants

In this study, a total of 120 children aged between 10 to 14 years were taken. Out of these 60 were from Delhi, wherein 30 were from families where both parents were working and 30 were from families where only a single parent was working. Similarly, 60 children were taken from Kerala, wherein 30 were from families where both parents were working and 30 were from families where only a single parent was working. Thus, a four group design was used in the study. These children were taken on availability basis from both places.

Tools

Coopersmith Self-Esteem Inventory: The Coopersmith Self-Esteem Inventory was developed by Coopersmith (1981) to measure attitude toward the self in social, academic, family and personal areas of experience. The inventory consists of 58 items to which one of the two responses, namely, "Like me" or "Unlike me," needs to be ticked. The items include statements such as "I often wish I were someone else," and "My parents usually consider my feelings." Kimball (1972) has reported internal consistency reliability of the inventory to range from .87 to .92 for children of grades 4 through 8. The construct validity of the measure has been confirmed by Kokens (1974, 1978) for students of grades 4 to 8 in studies comprising a total of 7600 students.

PGI General Well-being Measure (English version): The PGI General Well-being Measure (English version) was developed by S.K. Verama and Amita Verma (1989) to assess general well-being. It comprises of 20 items asking the subject to respond with a tick to the items which are applicable to him or her. The total number of items ticked gives the total well-being score. The total scores range from 0 - 20. Its split-half reliability is 0.98, whereas test-retest reliability index is 0.91. There is a positive correlation of 0.56 between the PGI General Well-being Measure and the Bradburn Wellbeing Scale.

RESULT

T-test was used to find out significant difference between different groups. Results are given in the following tables:

Table 1: Comparison of Well-Being of children from different groups based on the working status of parents (Single working / Both working) and culture (Delhi / Kerala)

<i>S.No. Comparisons</i>	<i>N</i>	<i>Mean</i>	<i>SD</i>	<i>SED</i>	<i>T</i>	<i>Sig.</i>
1 Both working (Delhi)	30	13.13	2.609	0.476	4.301	<0.05
Both working(Kerala)	30	16.20	2.905	0.530		
2 Single working (Delhi)	30	12.73	2.545	0.465	2.401	<0.05
Single working (Kerala)	30	14.57	3.319	0.606		
3 Both working (Delhi)	30	13.13	2.609	0.476	0.601	>0.05
Single working (Delhi)	30	12.73	2.545	0.465		
4 Both working (Kerala)	30	16.20	2.905	0.530	2.208	<0.05
Single working (Kerala)	30	14.57	3.319	0.606		

Table 1 presents a comparison of well-being of children from different groups based on the working status of parents, and culture i.e. Delhi and Kerala.

A perusal of the first row of Table 1 shows the mean well-being values of children from Delhi and Kerala whose both parents worked were 13.13 and 16.20 respectively, whereas their SDs were 2.609 and 2.905 respectively. The t-ratio obtained between the two means was 4.301, which was significant at 0.05 level of significance. The mean well-being score of children from Kerala was higher than of children from Delhi, and it was found to be statistically significant.

The second row of the same table shows the mean well-being values of children from Delhi and Kerala whose one parent worked were 12.73 and 14.57 respectively, whereas their SDs were 2.545 and 3.319 respectively. The t-ratio obtained between the two means was 2.401, which was not significant at 0.05 level of significance. The mean well-being score of children from Kerala was higher than of children from Delhi, and it was found to be statistically significant.

The third row of the table displays the mean well-being values of children from Delhi whose both or a single parents worked were 13.13 and 12.73 respectively, whereas their SDs were 2.609 and 2.545 respectively. The t-ratio obtained between the two means was 0.601, which was not significant at 0.05 level of significance.

The fourth row of the table shows the mean well-being values of children from Kerala whose both or a single parents worked were 16.20 and 14.57 respectively, whereas their SDs were 2.905 and 3.319 respectively. The t-ratio obtained between the two means was 2.208, which was significant at 0.05 level of significance. The mean well-being score of children having both parents as

working was higher than of children having a single parent as working, and it was found to be statistically significant.

Table 2: Comparison of Self-Esteem of children of different groups based on the working status of parents (Single working / Both working) and culture (Delhi / Kerala)

S.No.	Comparisons	N	Mean	SD	SED	t	Sig.
1	Both working (Delhi)	30	61.60	10.497	1.916	2.973	<0.05
	Both working (Kerala)	30	70.47	12.514	2.285		
2	Single working (Delhi)	30	60.47	10.030	1.831	0.440	>0.05
	Single working (Kerala)	30	61.87	14.248	2.601		
3	Both working (Delhi)	30	61.60	10.497	1.916	0.428	>0.05
	Single working (Delhi)	30	60.47	10.030	1.831		
4	Both working (Kerala)	30	70.47	12.514	2.285	2.484	<0.05
	Single working (Kerala)	30	61.87	14.248	2.601		

Table 2 presents a comparison of Self Esteem of children from different groups based on the working status of parents, and culture i.e. Delhi and Kerala.

A perusal of the first row of Table 2 shows the mean self-esteem values of children from Delhi and Kerala whose both parents worked were 61.60 and 70.47 respectively, whereas their SDs were 10.497 and 12.514 respectively. The t-ratio obtained between the two means was 2.973, which was significant at 0.05 level of significance. The mean self-esteem score of children from Kerala was higher than of children from Delhi and it was found to be statistically significant.

The second row of the same table shows the mean self-esteem values of children from Delhi and Kerala whose one parent worked were 60.47 and 61.87 respectively, whereas their SDs were 10.030 and 14.248 respectively. The t-ratio obtained between the two means was 0.440, which was not significant at 0.05 level of significance.

The third row of the table displays the mean self-esteem values of children from Delhi whose either both or a single parents worked were 61.60 and 60.47 respectively, whereas their SDs were 10.497 and 10.030 respectively. The t-ratio obtained between the two means was 0.428, which was not significant at 0.05 level of significance.

The fourth row of the table shows the mean self-esteem values of children from Kerala whose either both or a single parents worked were 70.47 and 61.87 respectively, whereas their SDs were 12.514 and 14.248 respectively. The t-ratio obtained between the two means was 2.484, which was significant at 0.05 level of significance. The mean self-esteem score of children having both parents as working was higher than of children having a single parent as working and it was found to be statistically significant.

DISCUSSION

The t-ratio between the mean values of well-being of children from Delhi and Kerala whose both parents were working was found to be significant ($t=4.301$, $p<.05$), with the children of Kerala scoring higher.

The fact that children of Kerala scored significantly higher on well-being than children of Delhi, despite there being no difference in the employment status of their parents, suggests that cultural factors are important in the well-being of children.

Being a metropolitan, industrial and political place, the values and behaviors of Delhi seem to be individualistic, but of Kerala these seem to be collectivistic. The family units in collectivistic societies often comprise, apart from childrens' own parents, their grandparents, aunts, uncles and cousins. Moreover, in such societies not only are children socialized to be responsible for their family, the family too is socially obligated to take care of children. Hence, all family members share the responsibility of childrens' well-being. By contrast, children are socialized to make their own decisions and become independent as early as possible in individualistic cultures (Maschinot, 2008), and members of the society are expected to be responsible for their own selves and their well-being (Diener, Diener & Diener, 1995). Thus, in such cultures, childrens' own parents, but not other family members, may be obligated to care for children. In such a condition, the children of individualistic culture are deprived of care, affection, and guidance of other family members which make them feel not so well as the children of collectivistic culture.

Further, when both parents are at work, they cannot possibly be available during office hours to tend to childrens' needs and spend quality time with them. In such cases, others, in lieu of parents, need to care for children during parents' absence. In collectivistic cultures, such a scenario may prompt family members including childrens' aunts, grandparents, cousins, or perhaps even neighbors to step up and provide care to children, as they may see it as a social obligation to work for each other's well-being. Australia's Aboriginal culture is a case in point, which is based on collectivist kinship and has safety and well-being of children at its core. Elders of Aboriginal families are especially valued and looked up to for providing support to their children and grandchildren. Moreover, all people in these close-knit communities keep a watch on each others' children, and so important information about childrens' whereabouts or activities might promptly reach their immediate family members from others in the community. Their kinship system also socializes children to bond with others and to have faith and confidence that all community members will act in the best interests of children (Child Family Community Australia, 2014). Hence, children from collectivist cultures may benefit by receiving quality and responsive childcare from extended family and community

members, even while their parents are away at work. On the contrary, children from individualistic cultures may have to rely chiefly either upon themselves, or on professional childcare services such as those provided by babysitters or crèches for childcare when their parents are away at work. Thus, they may not get childcare embodying warmth, responsiveness and the personal touch that children from collectivist cultures may get when their next of kin voluntarily comes forward to care for the children. Since, warm and responsive childcare, essential to childrens' well-being, are available to children of Kerala being collectivist society, is more conducive to childrens' well-being, they feel more well than the children of Delhi, an individualistic society.

The t-ratio between the mean values of well-being of children from Delhi and Kerala whose one parent was working was found to be significant ($t=2.401$, $p<.05$), with the children of Kerala scoring higher.

This result is in line with the earlier discussion suggesting that childcare practices of Kerala may be more conducive to childrens' well-being compared with Delhi, because in Kerala not just parents but all family members may tend to participate in rearing children and providing protection and affection to them. So, even for families where only one parent works while one is available at home to take care of a childrens' needs (in both Delhi and Kerala), the collective childcare provided by family members in Kerala may promote more enriching environment for childrens' well-being. Thus, children of Kerala may develop a greater degree of well-being than children of Delhi. At the same time, it should be noted that this difference in well-being has emerged the children of the two states, despite the family incomes being dependent on just one parent (in both states). As a whole it suggests that qualitative difference in parenting and childcare prevalent in Kerala culture may promote childrens' well-being more than the Delhi culture.

Empirical evidence also suggests that adolescents of Kerala perceive their parenting as quite positive. Parents from Kerala were perceived by their children as having realistic expectations from them, being accepting, being neither neglecting nor too pampering, being optimally protective, at the same time allowing for sufficient freedom (Maries, 2014).

The t-ratio between the mean values of well-being of children from Delhi whose both and one parent are working was found to be non-significant ($t=0.601$, $p>.05$).

Since a non-significant difference was obtained between the mean well-being scores of children of the two groups in Delhi, it may be discerned that additional income contributed by the second working parent did not have much impact on the well-being of children. It seems that quality childcare is necessary to childrens' well-being and that it may not be made up for, by affluence. Thus, it confirms

the notion that money alone is not enough for well-being. Also, it may be concluded that insofar childrens' well-being is concerned, responsive and caring parenting is essential, while economic affluence alone may not be of much help.

The t-ratio between the mean values of well-being of children of Kerala whose either both or one parents were working was found to be significant ($t=2.208$, $p<.05$), with the children whose both parents were working scored higher.

This finding seems to suggest that when Kerala's nourishing childcare practices are coupled with higher family incomes (such as in households where both parents work) there may be an even greater positive effect on childrens' well-being, as some optimal level of economic conditions are needed to feel well. There is little doubt that families with higher income, such as dual income families, will have the advantage of making a broader range of choices for their children which require monetary considerations. Parents from double-income households may have greater monetary power to make investments conducive to the well-being of children, thus increasing the likelihood of better outcomes for childrens' well-being, than either childcare practices or high income alone.

Empirical evidence affirms that parents' employment status, in general, can benefit low-income children through the provision of positive role models and stabilization of family routines (Wilson, 1996). Further, mother's employment, in particular, is not only associated with better maternal mental health (Hoffman & Youngblade, 1999) but it also benefits children in low-income families by providing additional income to the family. Also, the social and cognitive stimulation of the mother leads to more positive interactions with her children (Klebanov, Brooks-Gunn, & Duncan, 1994), thus benefitting children in multiple ways.

The t-ratio between the mean values of self-esteem of children of Delhi and Kerala whose both parents worked was found to be significant ($t=2.973$, $p<.05$), with the children of Kerala scoring higher.

The difference in self-esteem of children may have to do with the distinct socio-cultural make up and functioning of the two states which may affect childrearing and childcare. The demographics of Kerala show that it has a homogeneous population and the populace subscribes to a shared set of cultural values and norms. As mentioned earlier, a collectivist culture predominates in Kerala where family members not only share strong relational bonds and feelings of belongingness, but cooperate with, and care for each other. It is a closed and well-knit society where members of a family take good care of other members, and if needed, share the responsibility for other members such as that of caring for children and elders. Such cultural dynamics may work in the manner that even if both parents go out for work, other family members may take up the responsibility of providing care, protection and affection to their children and thus compensate for the parents' absence to a large extent. Hence, despite the absence

of their parents, children of such households of Kerala may get adequate quantity and quality of childcare, and they may still develop a healthy self-esteem.

On the contrary, demographics of Delhi reveal that it has a heterogeneous population, comprising largely of migrants from different states and it embodies a diverse set of cultural patterns, traditions, values and norms of conduct. Delhi typifies a metropolitan, open and individualistic culture, where members of a family and society are largely responsible for their own welfare. Consequently, if children whose parents go out for work need care, the remaining family members may not be able to afford much time or provide guidance, care and affection to these children. A scenario such as this may adversely affect childrens' self-esteem if both parents are working, and quality childcare may not be available to children in their absence. It appears then that Kerala's chiefly collectivist feature, may be more advantageous to the self-esteem of children whose both parents work than Delhi's essentially individualistic culture. Hence, compared to Delhi, greater mean scores on self-esteem were obtained for children Kerala.

Baumrind (1971) has asserted that child-rearing practices have been consistently found to relate with childrens' self-esteem. It has been shown that children and adolescents, whose parents are warm, responsive and provide reasonable expectation for behavior, tend to feel good about themselves. Warm and positive parenting lets young people know that they are accepted as worthwhile and competent. Conversely, highly corrosive parenting has been associated with a sense of inadequacy in children, because it communicates to children that they are ineffective in managing themselves and so, must be controlled by adults.

The t-ratio between the mean values of self-esteem of children of Delhi and Kerala whose one parent worked was found to be non-significant ($t=0.440$, $p>.05$).

This non-significant difference in self-esteem may be explained in the way that apart from cultural factors and child care, family income too may contribute to childrens' self-esteem. In families where only one parent works, limited family income may constrain children from achieving a higher level of self-esteem, which may not be the case for children of families in which both parents work, and thus the family income is high enough to not harm childrens' self-esteem. It seems likely that both culture and family income work together to impact childrens' self-esteem. Also, if the family income is below a certain level, even enriching parenting and childcare practices conducive to children's self-esteem (such as those prevalent in Kerala), may not be able to buttress the self-esteem of children; rather economic hardship and its negative consequences may still harm childrens' self-esteem. Whitbeck et al. (1991) found that family's economic adversity affects early adolescent self-esteem via decreased parental support to children and less involvement of parents in childrearing. Harvey (1999) had concluded that the

influence of early parental employment on child development was real, but it varied by the child's age, as well as with parents' marital and economic statuses.

The t-ratio between the mean values of self-esteem of children of Delhi whose both and one parents were working was found to be non-significant ($t=0.428$, $p>.05$).

As discussed earlier, though both culture and family income may account collectively for self-esteem of children, the result obtained for the children of Delhi suggest that differing family income did not seem to have much impact on childrens' self-esteem. The result shows that even though the self-esteem of children, whose both parents worked was marginally higher, it was not significantly higher than of children whose one parent worked.

It appears that culture in individualist context plays a important role in determining whether there would be any beneficial effects of higher income on childrens' self-esteem or not. It is possible that such effects are substantial only when children receive enriching parenting and childcare such as that received by children in collectivistic cultures. Perhaps that is the reason that a significant difference was not found in self-esteem of the two groups of children from Delhi, where an individualistic culture dominates, and which may not engender as wholesome childcare as is found in collectivistic societies, such as in Kerala.

The t-ratio between the mean values of self-esteem of children of Kerala whose both and single parents were working was found to be significant ($t=2.484$, $p<.05$), with the children whose both parents worked scoring higher.

The result obtained suggests that Kerala's collectivistic culture, due to its values of providing warm and responsive parenting and childcare is a key determinant of childrens' self-esteem. This is likely because, while a significant difference was not obtained in the self-esteem of children of Delhi, whose single or both parents worked in Delhi, a significant difference in self-esteem was obtained between comparable groups in Kerala. It seems that in families of Kerala, where both parents work, the higher family income complements warm and responsive childcare, by allowing for additional expenditure for children's better healthcare, nutrition, education and recreation, which may enhance childrens' self-esteem over and above the self-esteem which may be achieved by good childcare alone. Hence, in families of Kerala where both parents worked, children were found to have significantly higher self-esteem. Overall, it seems that the collectivistic cultural context prevailing in Kerala may augur better outcomes for the self-esteem of children.

It appears that it is largely the childcare values and practices rooted in culture and to some extent family income which determine childrens' well-being and self-esteem. Further, different cultures such as individualistic or collectivistic, may promote different childcare and childrearing customs, which may have varying effects on childrens' well-being and self-esteem. As a result, different levels of

well-being and self-esteem may be observed in different cultures, moderated, for the most part by culture and to some extent by family income. For instance, it must be noted that while greater well-being and self-esteem in children whose both parents were working was obtained in both Kerala and Delhi, this difference was found to be statistically significant only in Kerala. This may suggest that whatever benefits (including a higher family income) employment of both parents has on the self-esteem and well-being of children is substantial and therefore meaningful, only when the culture context is conducive. Overall, the results of this study indicate that the collectivistic culture of Kerala added with higher family incomes may dominate over the individualistic culture of Delhi and lower family incomes so far as conduciveness for better well-being and self-esteem of children is concerned.

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A STUDY OF IDENTITY CRISIS AND SELF-MONITORING IN INDIAN ADOLESCENTS

Lakshya Rawat, Pragyendu,** Mahesh K. Darolia,***
and Soaham Bharti*****

ABSTRACT

This paper outlines the utility of the concept of identity in personality development during adolescence. Identity crisis, a term which is used in colloquial speech, refers to a time of great turmoil in a person's life in which they struggle with understanding who they are. Adolescence is the period of life between the onset of puberty and the full commitment to an adult social role, known for the formation of personal and social identity and the discovery of moral purpose. In Erik Erikson's psychosocial theory of development, identity crisis is viewed as a natural transitional phase all people must go through to find out what roles they best fill in society. Identity crisis is part of his fifth stage of development - the Identity Cohesion versus Role Confusion stage - where a person develops either an identity or identity confusion. Present study was conducted on 200 participants using simple random sampling technique. Standardized measures such as Self Monitoring Scale and Objective Measure of Ego Identity Status were used for data collection. Results of the study revealed that females scored higher on foreclosure and boys scored higher on the achievement and moratorium statuses. Significant correlations were found among self monitoring, achievement and moratorium within boys while foreclosure and self monitoring were positively and significantly correlated within girls.

Keywords: Identity crisis, Turmoil, Adolescence and Development.

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- * Lakshya Rawat, Student, B.A. (Hons.) Psychology, Sri Aurobindo College (Evening), Malviya Nagar, University of Delhi.
- ** Mr. Pragyendu, Assistant Professor, Department of Applied Psychology, Sri Aurobindo College (Evening), Malviya Nagar, University of Delhi.
- *** Dr. Mahesh K. Darolia, Associate Professor, Department of Applied Psychology, Sri Aurobindo College (Evening), Malviya Nagar, University of Delhi.
- **** Soaham Bharti, Student, 12th, Sacred Heart Convent School, Ludhiana.

In human life span adolescence is that period of transition which links childhood and adulthood, in which socioemotional development is characterized by increased efforts to understand the self and the search for an identity. Decisions are not made once and for all, but have to be made again and again. Identity development does not happen neatly, and it does not happen cataclysmically (Cote, 2009). Young men and women are most vigorously driven to respond to the diversity of roles, activities, and values offered by societies in a bid to explore and create/take their place in the world. They are differentiated with regard to their experiences, their perspectives and their hopes for the future. They may respond to their social landscapes with enthusiasm, passion, idealism, indignation, protest, silence or apathy. They also evoke a rich variety of intense reactions from the others in the social order. On one hand, the youth are represented as reckless, irresponsible and uncommitted; on the other hand, as dedicated, deferential and conformist. Youth is not only viewed as a futuristic ray of hope, but also as a threat to the existing society. While pushed to the margins of political power within established order, they attract serious attention as the prime source of commodification and a profitable market.

Aspects of Youth

'Youth' as a biographical life stage is located between adolescence and adulthood. According to Arnett (1998) it begins with the end of secondary education and ends in their 20s for most people as the experimentation of the period is succeeded by more enduring life choices. It is distinct both demographically and subjectively from adolescence (roughly from the ages of 10 to 17) as well as adulthood (roughly from the age of 30). From a demographical perspective, this phase witnesses a high level of change and diversity. Youth represents multiple possibilities from delinquency to creative deviancy, rebellion to conformity, alienation to vigorous involvement in the spirit of the era. The energies of the vast majority of youth are absorbed in the efforts to acquire the skills and attitudes to negotiate the opportunity structure within modern economy for which they receive encouragement and appreciation from their peers, their teachers, and their family.

Identity, Identity Crisis and its Dimensions

Identity is an experience that lends a sense of self-sameness and continuity to a person across time and space (Erikson, 1968). A need for the sense of identity emerges in the face of incongruities and incompatibilities amongst the various elements of the self and/or ways in which one is positioned by particular social discourses of gender, class, race, religion and one's own self-understandings. These moments of disjuncture heighten self-awareness and reflection - the search for identity inevitably leads some adolescents to an identity crisis involving substantial psychological turmoil (Erikson, 1963). Erikson (1968) suggested that

upon resolving the crisis of identity versus role confusion, individuals are able to integrate all viewpoints about oneself and synthesize the many roles one has to play into a personal identity. Using Erikson's theory as a springboard, James Marcia (1980,) set forth four identity statuses, namely identity achievement, moratorium, foreclosure, and diffusion; they are defined by the self-reported experiences of crisis (exploration) and commitment. Adolescents are said to be identity achieved when they have gone through a period of exploration and made identity-defining commitments (Marcia, 1980). Individuals are said to be in moratorium status when they are currently in the process of exploration with either vague or absent commitments. Individuals of the foreclosed status harbor values, beliefs, and goals adopted from parents and/or authority figures without much critical thought. Identity diffused individuals lack exploration as well as commitment, because of which they tend to remain carefree and drift aimlessly.

Self-Monitoring

According to Snyder (1974, 1987), self-monitoring refers to the individual management of self-presentation, expressive behaviors, and non-verbal displays of affect. Self-monitoring individuals at the higher level regulate their eloquent self-presentation for maintaining desirable public appearances, thus focusing on the interpersonal significance of social behavior and using the expressions of others in social situations as cues for self-regulation. Self-monitoring individuals at the lower level express their actual thoughts and feelings, and according to Pledger (1992) self-monitoring increases throughout adolescence as individuals develop more sensitive perspective-taking skills, increased social acuity, and a high level of adaptive abilities in different communicative contexts. Some of the researchers found males to be significantly higher than females in self-monitoring (Nesler, Tedeschi, & Storr, 1995; Snyder, 1987; Snyder, Simpson, & Gangestad, 1986) while others reported no gender differences (Pledger, 1992). However, a large amount of the research in this area focuses on correlates of self-monitoring through documentation of attitude and behavior differences between high and low self-monitors that incorporate differences in their social behaviors, perceptions, and beliefs regarding others (Snyder, 1987). Snyder has also suggested that self-monitoring, identity and self-awareness are closely related. A pragmatic conception of self is shown by self-monitoring individuals at the higher level - a flexible "me for this situation" which describes identity as a consequence of roles corresponding to specific social situations (Snyder, 1987). In contrast, a more principled conception of self is shown by self-monitoring individuals at the lower level - an enduring "me for all times and places" which describes identity as a consequence of personal attributes and characteristics (Snyder, 1987).

A considerable amount of study has been dedicated to the comprehension of effects on and the results of identity development and the correlates of each

identity status. The present study attempts to contribute to this understanding by exploring the:-

- (a) Relationship between identity status and self-monitoring behavior; and
- (b) Gender differences in identity as well as self-monitoring in an Indian sample of adolescents.

METHOD

Sample

In order to achieve the objectives of the study, a sample of 200 late adolescents (90 boys and 110 girls) was taken from numerous schools and colleges of New Delhi, India. Ages ranged from 15 to 20 years; the mean age of boys was 17.53 years and that of girls was 17.41 years. The data were collected among matric (10th) qualified students.

Measures

- A. **Objective Measure of Ego Identity Status:** The Objective Measure of Ego Identity (abbreviated as OMEIS) is a self-report measure developed by Bennion & Adams in 1986, which has been considerably used for educational or clinical assessment of identity formation as well as research. It comprises of 64 items which determine the identity formation of a person across two domains with each one consisting of 32 items. Each of the areas of occupation, religion, politics and philosophical life style comprises of 8 items, thereby forming the *ideological domain*; while each of the areas of friendship, recreation, dating and sex roles includes 8 items, thereby forming the *interpersonal domain*. Both the domains measure identity achievement, moratorium, foreclosure, and diffusion. Graf (2003) succeeded in using the extended version of the scale (EOMEIS-2) on a sample of Indian adolescents, and reliability coefficients of different statuses of EOMEIS-2 (ranging from .72 to .87) were reported by Sandhu (2004) using Indian sample.
- B. **Self-Monitoring Scale:** The Self-Monitoring Scale (abbreviated as SMS) is an instrument developed by Snyder and Gangestad in 1986 that has been primarily used for assessing self-monitoring. Originally, this scale consisted of 18 items presented in a true-or-false format (for example: "I guess I put on a show to impress or entertain others," and "I have trouble changing my behavior to suit different people and different situations").

RESULT AND DISCUSSION

Pearson's method was used to determine the correlations of four identity statuses with the dimension of self-monitoring for the boys' and girls' sample, separately.

Table 1: Descriptive Statistics: Boys and Girls, N=200

Dimension	Boys		Girls	
	Mean	SD	Mean	SD
Self-Monitoring Total	36.87	2.79	35.57	3.44
Achievement Total	53.93	6.73	51.40	6.81
Moratorium Total	49.25	6.09	49.73	6.72
Foreclosure Total	43.78	8.05	46.42	9.83
Diffusion Total	47.30	5.34	47.59	6.49

Table 2: Correlation Table: Boys and Girls, N=200 for Self Monitoring and Dimension of Ego Identity

Dimensions	Self-Monitoring	Achievement	Moratorium	Foreclosure	Diffusion
Self-Monitoring	1	.21*	.20*	.11	.11
Achievement	.04	1	.38	.03	.02
Moratorium	-.06	.42	1	.42	.27
Foreclosure	-.26*	.15	.42	1	.36
Diffusion	-.13	.21	.41	.38	1

*= significant at .05 level

Note: R values below diagonal represent for girls; r values above diagonal represent for boys.

For boys' sample, correlation table indicated that self-monitoring is positively and significantly correlated with identity achievement (.21, $p < .02$) and identity moratorium (.20, $p < .03$). For girls' sample, correlation table indicated that self-monitoring is negatively and significantly correlated with identity foreclosure (-.26, $p < .002$).

Table 3: Multiple Regression Table: Boys and Girls, N=200

R	R Square	Adjusted R Square	F	Sig.
Boys	.26 ^a	.06	.02	1.56
Girls	.28 ^a	.08	.04	2.38

a. Predictors: (Constant), Diffusion, Achievement, Foreclosure, and Moratorium

b. Dependent Variable: Self-Monitoring

For boys' sample, the model summary showed that multiple correlation value is .26 for all the variance; but the value was not significant. For girls' sample, the model summary showed that multiple correlation value is .28 for all the variance; predictors explained 8% of the total variance, and the value was significant at .05 level ($F = 2.38$).

Table 4: Beta Table: Boys and Girls, N = 200

Variables		Beta	t	Sig.
(Constant)	BoysGirls		7.92511.888	.000.000
Achievement	BoysGirls	.172.086	1.492.833	.139.407
Moratorium	BoysGirls	.094.044	.729.378	.468.706
Foreclosure	BoysGirls	.045-.273	.369-2.558	.713.012*
Diffusion	BoysGirls	.071-.066	.626-.618	.533.538

*= Significant at .05 level

Beta table showed significant value of identity foreclosure in only the girls' sample. However, there was no significant predictor in the boys' sample.

The present study was conducted in order to explore the (a) relationship between identity status and self-monitoring behavior and (b) gender differences in identity as well as self-monitoring in an Indian sample of adolescents. This relationship between identity status and self-monitoring acknowledges the interrelatedness between social expectations (i.e., expectations of the social context) and individual self-understanding with respect to these two central features of adolescent development. India witnesses the interaction of Western values of modernization with a traditional culture, and conducting such a study aids in further exploring the correlates of identity formation as well as the generalization of identity development theory in a non-Western context.

As indicated by the results of the present study, self-monitoring was seen to be positively and significantly correlated with identity achievement and moratorium in boys. A positive and significant correlation was found between self-monitoring and identity foreclosure among girls. Not only these results maintain consistency with theoretical expectations, they also partially replicate Taylor's (1987) report which also highlights a relationship between the scores of self-monitoring and identity achievement - thereby conducing to the view that during adolescence, developing an adherence to an identity of choice leads to a balanced formation of self which does not necessarily have to be acclimatized to different partners and situations. Because the anticipated 'adult roles' of homemaking and motherhood are made clear to the growing girl rather early in her life, the future appears more foreclosed for female Indian adolescents; they tend to adopt the various traditional values and beliefs of the lineage they belong to, and are more in favor of pursuing life goals set by their elders and/or significant authority figures. Identity-achieved male Indian adolescents are able to manage a consistent presentation of the self in multiple contexts because they are more certain of who they are independently, regardless of their social climate. In a contrasting view, adolescents who are going through the early stages of identity development may take cues from others on monitoring, regulating, and controlling their behavior in public.

Consistently, male moratorium-status adolescents showed significant level of self-monitoring; generally considered a more mature stage of identity development than diffusion, moratorium increases with age the same way achievement does. The importance of the link between self-monitoring and mature stages of identity in an Indian sample suggests considerable amount of generalization to this interrelation in self-understanding among adolescents. The contribution to maturity in self-understanding by identity achievement results not only in a more genuine self-presentation in social contexts but also a reliable one. In order to bring about the confirmation of such a conclusion, however, further studies must be conducted in both the Western and non-Western contexts, hence exploring some other features of self-understanding which may mediate and/or elucidate this relationship.

The Indian society upholds tradition-backed stability and often stifles imagination-backed initiative while exerting strong pull towards maintaining psychological status quo around prescriptive role acts and hierarchies. The representatives of adult generation impose pedantic constraints on the imagination and initiative of the growing child in the name of guidance and protection – as a result of which he or she learns to constrict himself or herself to the point of overall inhibition, building deep and lasting resentments against the arbitrary power of the patronizing authority. For the creation of a wholesome identity in coming generations, healthy individualism needs to be promoted in youth. A spirit of inventiveness and imagination should be encouraged so that the young can learn what they must do by doing what they like to do. Also, the intergenerational relationships should be democratic because this much needed companionship holds out the possibility of keeping the hidden hatreds and envy between generations within limits and setting free the purposeful initiative of the young in the direction of futures which are permissible as well as possible and tangible. A new ethic needs to be inculcated in the coming generations that will reconcile the efficiency and individualism of free market with fairness and concern for the community at large.

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PSYCHOLOGICAL CAPITAL AS PREDICTOR OF SUBJECTIVE VITALITY IN BANK EMPLOYEES

Sarita Sood* and Arti Bakhshi**

ABSTRACT

The aim of this study is to assess the relationship between psychological capital and subjective vitality and contribution of psychological capital in developing subjective vitality. The data was collected randomly from 200 bank employees in Jammu using Psychological Capital Questionnaire and Subjective Vitality Scale. Pearson's Correlation as well as standard simple multiple regression were applied. A significant and positive correlation between all the dimensions of psychological capital namely efficacy, hope, optimism, resilience, and subjective vitality have been found. There has been significant contribution of each dimension of psychological capital in development of subjective vitality. These findings are relevant to human resource development.

Keywords: Hope, Optimism, Psychological capital, Resilience, Self efficacy and Subjective vitality.

The concept of positivity has recently been applied in the area of organizational behaviour (Luthans & Youssef, 2007). Positive organizational behavior emphasizes on developing the organization and the employees while nurturing the personal characteristics in employees. Self efficacy, hope, resilience, and optimism are the personal characteristics of the employee which when combined produce a higher structure called as psychological capital (PsyCap). It is evident that positivity brings about elevation of various desirable outputs in the work settings which further can promote the effectiveness and optimum outputs in an organization. PsyCap is a construct which is liable to change and has scope for improvement (Luthans, 2002). It requires constant motivation and upgrading specially needs

* Sarita Sood, Assistant Professor, PG Department of Psychology, University of Jammu, Jammu, Email: sarita.sood@yahoo.com

** Arti Bakhshi, Professor and Head, PG Department of Psychology, University of Jammu, Jammu.

attention lest it shows retrogression or fall in levels which can prove to be non conducive. PsyCap has an impact on the performance and has potential to bring positive organizational change (Avey, Wernsing, & Luthans, 2008). The way personal characteristics such as self efficacy, hope, resilience and optimism are evaluated by the employee has positive impact on well-being (Judge, Van Vianen, & De Pater, 2004).

Vitality refers to positive feelings such as invigorated mood, having high spirit and enthusiasm (Ryan & Fredrick, 1997). It is subject to change and is dynamic in nature. It is a function of both physical and eudaimonic factors (Younes, 2011) and is an indicator of personal well-being. When an individual is aware of such experiences or feel that the energy is available to self it is called as subjective vitality. The switches of subjective vitality are in the control of the employee for which an employee has accountability. To work with positive feelings and to enhance these is essential. Subjective vitality emerges from internal factors (Ryan & Fredrick, 1997) such as self esteem, perceived ability, positive feelings etc. Vitality reflecting energy may be effectively used for increasing the output and purposive actions (Ryan & Deci, 2008). Subjective vitality helps in indulging deeply into organizational tasks. In terms of involvement in work, the people reflecting vitality is more likely to be active and productive (Ryan & Fredrick, 1997). Employees with vigor tend to experience high levels of energy at work and invest effort in work (Ouweneel, Le Blanc, & Schaufeli, 2012).

The dimensions of PsyCap have been linked with the subjective vitality. Sweetman and Luthans (2010) have reported that the hope sets in employee the energy to work and fills him with an enthusiasm or vigor. It reflects the motivational property of PsyCap. Hope certainly is instrumental in building up higher levels of motivation. PsyCap acts as personal characteristic in generation of positive state in an employee which could be consequential for the work in the organizational set up. As per Snyder, Rand, and Sigmon, (2002) hope is perceived as the capability of an individual to plan in such a manner so that they are closer to the goal or are able to achieve the target and it motivates the person through goal directed energy used to achieve the target. It is evident that hope is a positive motivational state. Studies on relationship between social support and subjective vitality are suggestive of possible role of self efficacy in development of subjective vitality (e.g. Kasser & Ryan, 1999; Reis, Sheldon, Gable, Roscoe, & Ryan, 2000). The self efficacy brings the sense of self reliance in the employee in their own capacities even during the challenging situations (Bandura, 1997). Deep confidence in the potential enables the employee to tackle ups and downs and arrive at decisions. It allows to confidently derive conclusions in analytical and critical manner. The employees high on optimism are better equipped with the coping strategies and are most likely to adapt at the workplace (Luthans and Youssef, 2007). The component of optimism provides novice workable and most

suited pathways to enable to adjust and adapt. The link between resilience and vitality has been established based on the studies on the patients (e.g. Cromm, 2012). In a study conducted on a sample of 263 teachers in Iran, Kataki, Rezai, and Gorji (2013) reported correlation between dimensions of PsyCap and subjective vitality.

A person with subjective vitality is capable of becoming fully functioning and self realized. Vitality corresponds to the experience of oneself as potential 'origin' of action (deCharms, 1968). More the vitality greater the goal oriented involvement in actions. There are hardly any studies that have explored subjective vitality at work (Shirom, 2003). The positive states are just not the opposite of negative states and have their own precursors and consequences which need to be researched or explored. So far the studies conducted on antecedents and consequences of subjective vitality in work settings are in the stage of infancy. Yet to date there are only a few attempts to link up PsyCap and subjective vitality in organizations. Emphasis has been laid on increasing positive emotions and level of personal resources in order to create an engaged workforce (Ouweneel, Blanc, & Schaufeli, 2012).

With this backdrop current study aims to investigate the relationships between PsyCap (hope, optimism, self-efficacy and resilience) and subjective vitality in the bank employees in Jammu (India). The main focus will be on the possible contribution of PsyCap (self efficacy, hope, optimism and resilience) on subjective vitality.

Hypotheses

- H1** There will be significant correlation between PsyCap (self efficacy, hope, optimism and resilience) and subjective vitality.
- H2** PsyCap (self efficacy, hope, optimism and resilience) will be the significant predictor of subjective vitality.

METHOD

Sample

Using random sampling technique data was collected from 200 participants from various banks in Jammu, Jammu and Kashmir (India). In all the participants were in the age range 20-60 years with mean age 29.79. Of the total sample only 64 (32%) were male and 136 (68%) were female. As per the marital status 77 of 200 (38.5%) were married and 123 of 200 (61.5%) were unmarried. Seventy six of 200 (38%) were from rural area and 124 of 200 (62%) were from urban area. In terms of educational qualification 59 (29.5%), 90 (45%) and 51 (25.5%) were higher secondary, graduates, and post graduates respectively. Length of service of 166 (83%) participants was up to 10 years. 22 (11%) participants was beyond 10 years to 20 years, and 12 (6%) was beyond 20 years.

Procedure

The data collection was done from the branches of the banks located in rural area as well as urban area. Two branches of each bank i.e. one from rural area, Akhnoor and one from the urban area i.e. Jammu city were chosen. Sample was drawn from the branches of Jammu and Kashmir Bank, J&K Grameen Bank, HDFC Bank, Punjab National Bank, Citizen co-operative Bank, State Bank of India, Jammu Central Co-operative Bank. The researcher obtained permission of the bank manager of each branch and sought a list of employees in the bank. Using the random number generator the prospective participants were selected. On the stipulated date and time as per the appointment, the bank employees were approached. The questionnaires were given to the employees individually. Confidentiality of the responses was assured. The care was taken that each employee willing to participate filled in the questionnaire on their own. The filled in questionnaires were taken back immediately. The scoring was done as per the scoring instructions. The data was coded in Statistical Package for Social Sciences- Version 20.

Tools

Psychological Capital Scale (Luthans, Avolio, Avey, & Norman, 2007) is a twelve item and six point likert-type scale ranging from strongly agree to strongly disagree. The items for twelve item scale are extracted from twenty four item version of the scale. There are four components in the scale namely self efficacy (items 1-3), hope (items 4- 7), resilience (items 8-10) and optimism (items 11-12). The score of each dimension is averaged and the composite score is also calculated. The PCQ-12 has shown to have high reliability ranging from .87 to .93 (Baron, Franklin, & Hmielecki, 2013; Luthans, Youssef, Sweetman, & Harms, 2013; Norman, Avolio, & Luthans, 2010).

Subjective Vitality Scale (Ryan & Frederick, 1997) assesses the subjective vitality at state level. It is a seven item scale with seven point Likert type items ranging from 'not at all true' to 'very true'. The item 2 is reverse scored and is averaged with other items. The reliability coefficient of the scale is .84 to .86 (Ryan & Frederick, 1997).

Statistical analysis

Statistical Package for Social Sciences for Windows Version 20 was used for the calculations. Pearson's correlation and standard simple multiple regression were applied for the statistical analysis.

RESULT AND DISCUSSION

The result of some basic statistics (descriptive statistics) of study variables is presented in the Table 1. The Pearson's Product Moment Correlation was calculated for PsyCap (self efficacy, hope, optimism, and resilience) and subjective vitality (Table 2).

Table 1: Descriptive statistics for the study variables

	<i>N</i>	<i>Mean</i>	<i>S. D.</i>
Self efficacy	200	13.6500	3.96689
Hope	200	17.4150	4.61294
Resilience	200	13.0750	3.23290
Optimism	200	9.3500	2.68206
Subjective vitality	200	35.1200	7.52521

Table 2: Correlation Matrix

	<i>Self Efficacy</i>	<i>Hope</i>	<i>Resilience</i>	<i>Optimism</i>	<i>Subjective Vitality</i>
Self Efficacy	1				
Hope	.612**	1			
Resilience	.484**	.479**	1		
Optimism	.456**	.438**	.398**	1	
Subjective Vitality	.551**	.523**	.592**	.471**	1

** Significant at .01 level

As per the Table 2 the correlation of all the dimensions of PsyCap and subjective vitality has been found to be highly significant at .01 level. All the correlations are moderate and positive. This clearly shows that higher the PsyCap (self efficacy, hope, resilience, and optimism) of an employee greater is the subjective vitality likely to be experienced and vice versa. In a study conducted on nurses in Korea, Lee and Oh (2007) also reported a positive relationship between self efficacy and vitality. Resilience has been also linked with subjective vitality (Cromm, 2012). Positive relationship between self efficacy, hope, resilience and optimism were reported in a study conducted on elementary teachers in Iran (Kataki, Rezai, & Gorji, 2013). In the light of the previous studies the hypothesis stating that there will be significant correlation between PsyCap (self efficacy, hope, optimism and resilience) and subjective vitality is accepted.

A standard multiple regression analysis was conducted to evaluate how much PsyCap (self efficacy, hope, resilience, and optimism) scores predicted subjective vitality in the bank employees. The linear combination of PsyCap (self efficacy, hope, resilience, and optimism) scores was significantly related to subjective vitality in bank employees, $F(4, 195) = 45.957, p < .001$. The multiple correlation coefficient was .697, indicating that 48 percent of variance of the subjective vitality can be accounted for by the linear combination of PsyCap (self efficacy, hope, resilience, and optimism) scores. The multiple R for the relationship between the set of independent variables and dependent variable is 0.697 which is strong. The probability of the F statistic (45.957) for the overall regression relationship is

<0.001 , the null hypothesis that there is no relationship between the set of independent variables (self efficacy, hope, resilience, and optimism) and the dependent variable (subjective vitality) is rejected. Rather there is statistically significant relationship between set of independent variables (self efficacy, hope, resilience, and optimism) and dependent variable (subjective vitality). For self efficacy, the probability of t statistic (5.312) for the b coefficient .389 is <0.01 . Hence it is concluded that there is statistically significant relationship between self efficacy and subjective vitality. The t value (2.419) for the b coefficient .270 is <0.05 so the relationship between hope and subjective vitality is also established. In case of resilience the b coefficient .833 with t value (5.868) is <0.001 hence the resilience is also associated with subjective vitality. The t value (2.547) for b coefficient for optimism also is <0.05 showing an association between optimism and subjective vitality. This leads to acceptance of the research hypothesis that PsyCap (self efficacy, hope, optimism and resilience) will be the significant predictor of subjective vitality.

The studies conducted in the past show that PsyCap is very important in determining positive organizational behavior (Avey, Luthans, & Jensen, 2009; Avey, Wernsing, & Luthans, 2008; Luthans, Avolio, Avey, & Norman, 2007). The employees benefit from positive PsyCap and are likely to work with energy and vigor. People working with vitality are self realized and can be an asset to an organization. This gives us an insight into the need of creating such conditions so that the employees can experience internal or personal states such as self efficacy, hope, resilience and optimism. A little research in the past has examined an association between PsyCap (self efficacy, hope, resilience and optimism) and subjective vitality in work settings. The employees high in terms of PsyCap are capable of providing higher values to the organization. Thus, by investigating the association between these two factors (PsyCap and subjective vitality), the present study facilitates our understanding of how PsyCap determines experiences of vitality in the employees.

Implications

The results confirm the importance of increasing the positive PsyCap and consequently the vitality in the employees so that they may contribute to the organization while becoming fully functional. Positive organizational psychology calls for application of its principles and findings for the enhancement of positive attributes among the bank employees and for their optimal development. PsyCap can be developed (Luthans, Avey, Avolio, Norman, & Combs, 2006). Based on the findings, recommendations are offered to managers, practitioners and policy-makers for an increased focus on developing personal capacities which would focus on bank employees physical and eudaimonic well-being. Providing congenial, positive and energizing work environment is necessary for optimum development and maintenance of personal capacities or resources.

As per broaden and build theory the positive emotions can build positive resources and may predict well-being in the long run (Fredrickson, 2001). These findings are relevant to human resource development. The study adds to the existing literature as the exploration into these variables in work settings is in initial stages.

DIRECTIONS FOR FUTURE RESEARCH

While the findings support the notion that PsyCap (self efficacy, hope, resilience, optimism) is associated with subjective vitality, the research is broad and provides good starting point for future research that might be oriented toward finding out the antecedents of PsyCap and also exploring the other possible determinants of subjective vitality. Future research may be oriented towards determining the causal relationships while incorporating the longitudinal designs.

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INFLUENCE OF DIETARY PREFERENCES ON INATTENTION, HYPERACTIVITY AND IMPULSIVITY IN CHILDREN

Jaya A.T*, and Chandana D. Karathully**

ABSTRACT

The dietary preferences are changing among children and youngsters. Their changed dietary preferences have then impact on physical and psychological health of children. This article examines the relation between dietary preferences and the inattention, hyperactivity and impulsivity in children between the ages of 5 to 15 who were divided on the basis of preference for homemade food, non-vegetarian food and junk food. They were assessed on the domains of inattention, hyperactivity and impulsivity using the DSM – IV- criteria and ICD -10 criteria for inattention, hyperactivity and impulsivity in Attention Deficit Hyperactivity Disorder. The results indicated that who preferred non-vegetarian food and junk food had more problems of inattention, hyperactivity and impulsivity than other children who preferred homemade food.

Key Words: Inattention, Hyperactivity, Impulsivity, Dietary preferences, Junk food and Home made food.

Food is one of the most essential factors for human existence and well-being. Ayurveda considers food as one of the pillars that help to sustain life by providing strength and growth of the human body. According to Upanishads, Man is what he eats. Through proper consumption of food, one can maintain health, and the improper use and faulty consumption of food can lead to different kinds of illnesses. Hence, Ayurveda explains several dietary regimens for the adequate consumption of food, like consideration of quality, processing and quantity of food before consumption. The usage of wholesome food that is appropriate to the season and particular bodily characteristics were considered to be the key to

* Asst Professor, Department of Psychology, Prajyoti Niketan College, Pudukad, Thrissur, Kerala jayasunil.at1@gmail.com, 9446618814

** PG Scholar, Department of Psychology, Prajyoti Niketan College, Pudukad, Thrissur, Kerala, chandanadk@gmail.com, 8547452283

maintaining health and vitality. However, the development of different dietary preferences and practices has led to health crises among people. The increasing incidence of various types of lifestyle disorders is an example for this. McCartney (1969) holds that many of our foodstuffs are now artificial, and specially designed to tickle the palate and tempt the appetite and that we must exercise great care in the selection of our food. But, the children of the current era are not fond of the traditional tastes. They are attracted to the fast foods and carbonated drinks than healthy snacks.

As our development and survival are dependent on the nutrition we receive, the impact of the food on our well being is beyond questioning. Several researches have been conducted in the area of dietary habits. Bree, Przybeck and Cloninger (2006) investigated association between diet and nature, and reported that differences in personality style are reflected in the diet. Harikrishnan and Immanuel Thomas (2009) studied the dietary preferences in relation to personality and character and found that the vegetarians were lower in activation and at the same time greater instability and thoughtfulness dimension of the temperament compared to non-vegetarian group. Different researches are being conducted in the domain of how the nutritional quality of what we eat can affect our behavior. Several reports suggest that the nutritional deficiencies can lead to several disorders by affecting the brain functioning.

Attention-deficit/hyperactivity disorder (ADHD) is characterized by a pattern of diminished sustained attention and higher levels of impulsivity in a child or adolescent than expected for someone of that age and developmental level. Whereas in the past, hyperactivity was believed to be the underlying impairing symptom in this disorder, the current consensus is that hyperactivity is often secondary to poor impulse control. Impulsivity and hyperactivity share one dimension in today's diagnostic criteria for ADHD. Current consensus that the etiology of ADHD involves complex interactions of neuroanatomical and neurochemical systems. The suggested contributory factors for ADHD include prenatal toxic exposures, prematurity, and prenatal mechanical insult to the fetal nervous system.

Food additives, colorings, preservatives, and sugar have also been proposed as possible causes of hyperactive behavior. The controversy began in 1973 when Benjamin Feingold, MD, Chief Emeritus of the Department of Allergy at the Kaiser Permanente Foundation Hospital and Permanente Medical Group in San Francisco, presented an invited paper at the annual meeting of the American Medical Association. He proposed that much of the hyperactivity and learning problems seen in school-aged children were because of the ingestion of certain foods and food additives. He suggested a diet called Kaiser Permanente diet or K-P diet, free of foods containing natural salicylates and all artificial food colors (AFCs) and flavors which could be effective in children with ADHD. Some studies have indicated that some children with ADHD, in addition to being sensitive to artificial

food dyes, are also sensitive to common, nonsalicylate containing foods (milk, chocolate, soy, eggs, wheat, corn, legumes) and to grapes, tomatoes, and orange, which do contain salicylates. Since the dietary practices are learned during the childhood years, the need to educate them about and develop healthy dietary preferences is assuming greater importance in the current era.

Inattention is inability in arousing or sustaining attention evidenced in both study and play activities. Hyperactivity is brought about by excessive physical activity or restlessness as shown by running and climbing around or fidgeting with hands excessively. Impulsivity is the nature of behavior that is acted out without forethought and considering the odds. Even though, the three dimensions come under the spectrum of Attention Deficit Hyperactivity Disorder, there is increased prevalence of inattention, hyperactivity and impulsivity in children these days even though they cannot be diagnosed as ADHD. The present study aims to find how dietary preferences are related to the reading habits and the dimensions of inattention, hyperactivity and impulsivity in children.

METHOD

Sample

The sample for the study consisted of 59 children of age from 5 to 15, who are randomly selected from different schools of Thrissur Town, Kerala. They are divided into two groups of age 5 to 10 ($N = 21$) and 11 to 15 ($N = 38$). There were 39 male children and 20 female children.

Procedure

The respondents indicated their preference to homemade food, non-vegetarian food and junk food. The survey method was used and the variables were assessed through questionnaires that were filled out by the children. The respondents were grouped into different groups according to their preferences. The two groups on their preference for homemade food were those who preferred or didn't prefer. The four groups regarding preference for non-vegetarian/junk food were those who never take them, who occasionally take them, who often take them and who take them every day.

The inattention, hyperactivity and impulsivity of the were measured using the DSM - IV- criteria and ICD -10 criteria for inattention, hyperactivity and impulsivity in Attention Deficit Hyperactivity Disorder. The results were analyzed using SPSS software.

RESULT AND DISCUSSION

Initially the scores obtained by the lower and higher age respondents of inattention, hyperactivity and impulsivity were compared. The two groups (5-10 years) and (11-15 years) differed significantly in hyperactivity and impulsivity and from the mean score it can be seen that the children belonging to the group

of 5 to 10 years had higher scores on hyperactivity and impulsivity. Even though ADHD can't be diagnosed before 7 years of age it is noted that the symptoms can be found in younger children too. Venkata and Panicker (2013) also reported that prevalence of ADHD in primary school children in India was 11.23%. Thus it appears that ADHD symptoms in younger children diminish as they approach adolescence.

Table 1: Mean, standard deviation and t scores for the two age groups

Domain	Age - groups	N	M	SD	t value
Inattention	group 1	21	5.05	6.26	0.39
	group 2	38	4.39	6.27	
Hyperactivity	group 1	21	3.86	6.64	2.18 *
	group 2	38	0.53	2.93	
Impulsivity	group 1	21	1.29	2.79	1.17 *
	group 2	38	0.50	1.72	

* $p < .001$

Table 2: Mean, standard deviation and t scores for gender groups

Domain	Gender	N	M	SD	t value
Inattention	Male	39	5.87	6.83	2.62*
	Female	20	2.20	3.93	
Hyperactivity	Male	39	2.51	5.79	2.53**
	Female	20	0.15	0.49	
Impulsivity	Male	39	1.15	2.60	2.63**
	Female	20	0.05	0.22	

* $p < .01$; ** $p < .001$

Table 2 indicates the comparison where the two gender groups differed significantly on all the domain of ADHD. From the mean values, it is clear that the male children were higher on the three dimensions. Earlier researches indicate that ADHD is more prevalent in boys than in girls, with the ratio ranging from 2 to 1 to as much as 9 to 1 (Sadock & Sadock, 2007). Venkata and Panicker (2013) also found that prevalence among primary school children in Indian context to be higher among the males (66.7%) as compared to that of females (33.3%).

Table 3 shows the comparison of groups according to their preference for homemade food on inattention, hyperactivity and impulsivity. The result reveals that there are significant differences between the groups in inattention, hyperactivity and impulsivity. From the mean values it is evident that the children who don't prefer homemade food (preference 0) have higher scores on inattention, hyperactivity and impulsivity. The symptoms of inattention,

hyperactivity and impulsivity are more shown by the children who don't prefer homemade food.

Table 3: Mean, Standard deviation and t scores obtained by the groups based on homemade food preference

Domain	Preference	N	M	SD	t value
Inattention	0	27	6.33	7.95	1.88*
	1	32	3.19	3.85	
Hyperactivity	0	27	3.59	6.70	2.68*
	1	32	0.13	0.42	
Impulsivity	0	27	1.48	2.94	2.20*
	1	32	0.19	0.90	

* $p < .001$

Table 4: Results of one way ANOVA obtained by the groups based on junk food preference

Variables	Sum of Squares	Df	Mean Square	F ratio	
Inattention	Between groups	176.714	3	58.905	1.57
	Within groups	2069.082	55	37.620	
	Total	2245.797	58		
Hyperactivity	Between groups	350.827	3	116.942	6.44**
	Within groups	999.275	55	18.169	
	Total	1350.102	58		
Impulsivity	Between groups	60.883	3	20.294	5.23*
	Within groups	213.253	55	3.877	
	Total	274.136	58		

* $p < .01$; ** $p < .001$

Table 4 indicates the results on a comparison between the groups on the preference for junk food on the three domains of inattention, hyperactivity and impulsivity. The results show that the groups (who never take junk food (N=4), who take occasionally (N=26), who take often (N=28), who take everyday (N=1)) differed significantly on the areas of hyperactivity and impulsivity, but not on inattention..

Table 5: Results of one way ANOVA obtained by the groups based on non vegetarian food preference

Variables	Sum of Squares	Df	Mean Square	F ratio	
Inattention	Between groups	342.448	3	114.149	3.30*
	Within groups	1903.348	55	34.606	
	Total	2245.997	58		
Hyperactivity	Between groups	198.618	3	66.206	3.16*
	Within groups	1151.484	55	20.936	

	Total	1350.102	58		
Impulsivity	Between groups	34.776	3	11.592	2.66*
	Within groups	239.360	55	4.352	
	Total	274.136	58		

*p<.05

Table 5 shows a comparison between groups on the non-vegetarian food preference on the dimensions of inattention, hyperactivity and impulsivity. The groups (children who never take non vegetarian food (N=6), take occasionally (N=20), take often (N=19) and take everyday (N=14)) were analyzed by one way ANOVA. The results show that there were significant differences in the scores obtained by groups on all three domains. That is the groups differ significantly in the scores of inattention, hyperactivity and impulsivity.

Table 6: Coefficients of correlation obtained among different variables

Variables	Homemade fd pref.	Junk fd pref.	Non veg fd pref.
Homemade fd pref.	1	-.480**	-.153
Junk fd pref.	-.480**	1	.472**
Non veg fd pref.	-.153	.472**	1
Inattention	-.254	.195	.146
Hyperactivity	-.361**	.382**	.146
Impulsivity	-.299*	.289*	.109

*p<.05, **p<.01, ***p < .001

The obtained data was also subjected to correlational analysis in order to study the relation between preferences. Table 6 shows the Pearson correlation results of the above-mentioned variables. It gives a better picture on how these variables are related to each other.

As per the results, the hyperactivity is positively correlated to junk food and negatively correlated to preference to homemade food. As the food preferences are also related to impulsivity in the same manner, both hyperactivity and impulsivity are influenced by the food preferences. It is strongly indicated by the negative correlation of these dimensions to preference to homemade food and positive correlation of these to preference to junk food. There is no conclusive evidence about the relation of diet and ADHD even though there are several hypotheses about the involvement of food additives, certain kind of food materials and sugar can enhance the hyperactive behavior. The studies regarding the diet preference and ADHD are rare, but further researches should focus on the changing lifestyle and the increasing incidence of ADHD among children. There are also negative correlations among the homemade food choices preference to junk food. This indicates the pattern of interests in the children of the new generation. They prefer the western lifestyle and food preferences than having the conventional lifestyle

of Keralites. The positive correlation of non-vegetarian food preference to junk food preference and negative correlation to homemade food preferences also indicate this. The changing lifestyle and urbanization also affecting the choice of children can lead to a number of health hazards like lifestyle diseases. The developing pattern of inability of children to concentrate in studies or to utilize their aptitudes constructively to their scholastic development can be attributed to their changing preferences.

Further studies are to be conducted to explore more on the impact of these problems. More research is required to explore and probe the situation further to develop a robust theoretical model relating the behavior problems to the changing pattern of lifestyle.

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HEALTH HABITS, KNOWLEDGE AND HEALTH BEHAVIOUR AMONG SCHOOL-GOING ADOLESCENTS

Salma Kaneez

ABSTRACT

The purpose of the present endeavour is to ascertain habits and existing level of awareness of life-style related diseases among school-going adolescents and its impact on their health behaviour. Adolescence is a time of experimentation where healthy and unhealthy behaviours are either discarded or retained as lifelong habits. During this period, new and healthier behaviours can be learned and established. Adolescents seek independence in most areas of health behaviour. Their habits and knowledge of health maintenance such as exercise, nutrition/diet, and knowledge about chronic conditions of AIDS, cancer, asthma and risk behaviours including alcohol use, smoking, and drug abuse may influence health related behaviour. A sample of 65 adolescents (35 boys, 30 girls) was prepared and age appropriate self-designed questionnaires were employed to collect the information. Chi Square and Correlation were used to analyse the collated data. The results revealed poor level of awareness of the life-style diseases, their symptoms, in general and associated behavioural and risk factors, in particular. A significant positive relation was found between knowledge about life-style diseases and health behaviour among adolescents. Findings have implications for preventive healthcare policies in India where increasing burden of non-communicable diseases can be arrested in order to maximize healthcare needs of the people with the given health delivery system.

Keywords: Health habits, Knowledge, Health behaviour, Adolescents and Preventive health care.

Adolescence is the life stage when the individuals begin to formulate their health habits. Many healthy and unhealthy habits developed in adolescent period have life-long impact on health outcome. During adolescence, young people are

* Dr. Salma Kaneez is UGC Post-Doctoral Fellow, Dept. of Psychology, AMU., Aligarh. Email:ahzaml@yahoo.com

assigning responsibility for their own eating behaviour, health attitudes and behaviour (Fleming-Moran & Thiagarajaht, 2005). Adolescents also carry the highest risk of morbidity and mortality from life-style related diseases. Health reports revealed that burden of non-communicable diseases is increasing globally and poses a major public health concern. The non-communicable diseases are estimated to account for 53% of all deaths in India (WHO, 2005). The life-style diseases like diabetes mellitus, hypertension, coronary heart diseases and respiratory diseases have been related to the prevalence of risk factors in childhood. Several studies have documented that people of early twenties tend to engage in behaviours damaging to health to a greater extent than those in other age ranges. Many of the risk factors for non-communicable diseases like smoking, physical inactivity, inappropriate dietary practices and hypertension have their roots in adolescence (Divakaran *et.al.*, 2010). These behaviours may result in immediate health problems and may translate the risk into chronic diseases such as diabetes, hypertension, certain cancers and heart diseases in the long run. In fact, perceptions, beliefs and attitude formed in the early age play an important role in adoption and maintenance of a variety of health and nutritional habits.

Eating pattern established during adolescence may remain throughout the life cycle (Stewart & Tinsley, 1995). Incidence of dietary inadequacies in adolescents is high. An increasing need of independence and a desire to make life style choices that confer to peer ideals and differ from those of family, place adolescents at risk of poor nutritional status (WHO, 2002). Adolescents, therefore, seem to adopt a life-style that negatively affects their nutritional and health status. In a study, Al-Almaie (2005) found that knowledge of healthy diet among school students was inadequate. In western industrialized countries, excessive fat consumption and insufficient fibre, fruit and vegetable consumption are related to health problems. In addition, excessive consumption of calories combined with lack of exercise has made obesity a major health problem. Dietary and exercise habits often originate in childhood, but are established more permanently during adolescence (Cohen, Brown, & Felix, 1996). Despite the well known benefits of physical activity, most adults and children lead a sedentary life-style and are not active enough to achieve these health benefits. The potential health gains of regular exercise include lower cardio-vascular morbidity and mortality, lowered BP, increased metabolism of carbohydrates, and fats as well as range of psychological benefits such as improved self esteem, mood status, reduced life stress and anxiety. Healthy habits among children, therefore, lay the groundwork for the positive youth development. Thus, socio-cognitive factors play fundamental role in influencing health behaviours and health outcomes during the growing stage.

Health behaviour refers to any activity undertaken by individual regardless of actual or perceived health status for the purpose of promoting, protecting or maintaining health and well-being. In the present study, health behaviour was

defined in terms of attitude towards health care, health consciousness and carelessness. Behaviours within this definition include medical service usage, compliance with medical regimens, and self-directed health behaviour. Behaviour patterns, actions and habits that relate to health maintenance, restoration and health improvement are also covered in the definition (Gochman, 1997).

Objective

The main objective of the study was to assess the adolescents' knowledge of life-style related chronic diseases and its association with their health habits and health behaviour /care.

METHOD

Sample

This was a cross sectional survey. The participants were 65 school-going adolescents (35 male; 30 female). They were between the age of 16-19 years belonging to the lower segment of middle class families (income up to Rs. 20,000 p.m.) attending private secondary/senior secondary schools in Aligarh. Purposive sampling technique was used for data collection.

Inclusion/Exclusion Criteria

Adolescents with age range of 16-19 years without any serious illness belonging to lower section of middle class were included in the sample. Others with any serious illness and having upper middle class family status were not the participants of the study.

Tools

- (i) **Knowledge Scale (K-Scale)** developed by the researcher was used to measure the knowledge about four life-style related diseases (i.e. diabetes, hypertension, asthma and heart disease). The scale has 16 items related to the definition/ meaning, symptoms, causes and risk factors about diseases (4 items each). It has three response categories: Yes (2), Do not know (1), and No (0). The scores for subscales ranged between (0-8) and for full scale (0-32). High scores indicate good knowledge about life-style related diseases. Participants were divided into three categories as showing poor, fair and good knowledge on the basis of percentile score.
- (ii) **Health Habits Scale** were measured by self-developed Health Habits Scale. It consists of two parts. First part measures diet and nutritional intake. It has 7 items with four response categories ranging from Not at all (0) to Always (3). Scores ranged between 0-21 with high scores indicating healthy habits. The second part measures exercise and physical activity. It has 4 items with scores range of 0-12, where high scores indicating physically active and vice-versa.

- (iii) **Health Care Scale:** Health Care Scale of Adhami & Kureshi (1992) was used to measure attitude towards health care. The scale comprises 30 items, out of this 15 reflect health consciousness and other 15 reflect health carelessness (3,4,6,8,9,10,13,15,18,19,21,24,27,29 and 30). It is a 5-point Likert Scale consisting of Strongly Agree to Strongly Disagree response categories. Items measuring health consciousness get a score of '5' for Strongly Agree, and '1' for Strongly Disagree. While, items measuring carelessness in attitude are scored in reverse order. The alpha value with the present sample was found to be 0.70.

Statistical Analysis: Descriptive statistics, frequency, percentage and Pearson's Correlation were used for analysis.

RESULT AND DISCUSSION

Demographic Characteristics of Respondents

About 42% of participants belonged to the lower socio-economic strata, and 58% hailed from middle income groups of the society. Out of 65 students, 65.3% of respondents' parents were having education up to senior secondary school and the rest were graduates. 78.7% had Urban, and 21.3% rural background. Moreover, 32.3% were having the family history of hypertension, 23.1% of diabetes, 15.4% of heart disease, 1.5% of asthma and remaining 27.7% did not show history of any life-style related disease.

Table-1: Respondents' Knowledge of life-Style related diseases in terms of Percentage (%) and Frequency.

level of knowledge	Meaning		Symptoms		Behavioural factors		Risk factors	
	f	%	f	%	f	%	f	%
Poor(0-4)	22	33.80	31	47.70	34	52.30	24	36.90
Fair(5-6)	23	35.40	18	27.70	12	18.50	24	36.90
Good(7& above)	20	30.80	16	24.60	19	29.20	17	26.20
Total	65	100	65	100	65	100	65	100

Respondents' Knowledge about Life-style related Chronic Diseases

Table-1 shows respondents' knowledge of life-style related chronic diseases in terms of understanding, symptoms, behavioural factors and risk factors. As evident from the table, about 33.80% (n=22) adolescents had poor, 35.40% (n=23) had fair and remaining 30.80% (n=20) had good knowledge about definition of diabetes, asthma, hypertension and heart diseases. Overall, more than two-third (69.20%) of adolescent did not possess good knowledge about meaning of chronic diseases.

Respondents' Knowledge about Symptoms of Chronic Diseases

Table reveals that 47.70% (n=31) had poor, 27.70% (n=18) had fair and 24.26% (n=16) had good knowledge about the symptoms of diseases. This means only 1/4th of the students show good knowledge of the symptoms of the chronic diseases.

Respondents' Knowledge about Behavioural factors in Chronic Diseases

As clear from the table, 52.30% (n=34) had poor, 18.50% (n=12) had fair and 29.20% (n=19) had good knowledge about behavioural factors (life-style) in chronic diseases. Approximately 71%, a majority of students had poor to fair knowledge about role of behavioural factors in chronic diseases.

Respondents' Knowledge about Risk factors in Chronic Diseases

Equal number of respondents, 36.90% (n=24) had poor and fair knowledge respectively and remaining 26.20% (n=17) had good knowledge about risk factors

On the whole 74% adolescents had inadequate knowledge about the life-style related diseases. The result was consistent with the findings obtained by Nti, et.al. (2012). They reported that the knowledge of diet related diseases in terms of understanding, causes and prevention of diabetes, hypertension, and obesity among day senior high school adolescents in Ghana was poor.

Table 2: Dietary Habits of Students.

<i>Health Habits</i>	<i>Male</i>	<i>Female</i>	<i>E</i>
Poor Habits	18 (51.4%)	24 (80%)	65.70%
Good Habits	17 (48.6%)	6 (20%)	34.30%
Total	35 (100.0%)	30 (100%)	65 (100.0%)

Chi Square (χ^2) = 5.57, $p < .01$

Perusal of table-2 revealed that 80% girls and 51.4% boys had poor and rest 48.6% and 20% girls had good eating habits. This means participants' dietary habits were generally poor with more than half (65%) having unhealthy eating patterns. They seemed to be unaware about nutritional value of their diet, did not make efforts to eat high fibre and low calories food. The daily consumption of fruits and milk was also low. Significant association ($\chi^2 = 5.57$, $p = .01$) was observed between sex and health habits. More females had poor health habits

Table 3: Frequency and percentages of Exercise and physical activity among Students.

<i>Health Habits</i>	<i>Male</i>	<i>Female</i>	<i>E</i>
Poor Habits (Exercise & Physical Activity)	16 (45.7%)	25 (83.3%)	64.50%
Good Habits (Exercise & Physical Activity)	19 (54.3%)	5 (16.7%)	35.50%
Total	35 (100.0%)	30 (100.0%)	

Chi Square (χ^2) = 8.27, $p = .01$

Data presented in Table-3 shows that 64% respondents (83.3% girls and 45.7% boys) had poor exercise-physical activity habits and rest 36 % (16.7% girls & 54.3% boys) had good exercise habits. This means more than half of the students had unhealthy exercise and physical activity habits. Significant statistical associations existed ($\chi^2 = 8.27$, $p = .01$) between sex and physical activity. Girls students lived more sedentary life as compared to boys. This might be due to the fact that in our society boys were more physically active and enjoyed more freedom to participate in outdoor games, excursions, and join gym, etc.

It is evident from the Table-4 that majority of the students (56.9% ; 76.7% girls & 37.1% boys) were health conscious and only 43.1% (62.9% boys & 23.3% girls) students were careless about their health. Significant Chi-Square value revealed that more girls than boys had positive attitude towards health care when ill.

Table 4: Association between study variables.

<i>Variables</i>	<i>(1)</i>	<i>(2)</i>	<i>(3)</i>	<i>(4)</i>	<i>(5)</i>
Knowledge about Chronic Diseases (1)	1				
Health Habits Diet and Nutrition (2)	0.31*	1			
Exercise and Physical Activity (3)	0.48**	0.48**	1		

** $p < .01$ * $p < .05$

Table-4 shows that adolescents' knowledge of chronic diseases was positive and significantly associated with their dietary habits ($r = 0.31$, $p < .05$) and exercise

and physical activity ($r = 0.48, p < .01$). But there found a significant negative relation between knowledge about diseases and health carelessness ($r = -0.30, p < .05$). This means adolescents with sufficient knowledge about the meaning, symptoms, behavioural factors and risk factors related with life-style diseases were more conscious about their diet and nutrition and tried to take healthy diet i.e. low in salt and calories, high in fibre with fruits. They were also physically active, participate in games and to some extent do exercise/ walk. In contrast, those with poor knowledge were not bothered about healthy/ unhealthy eating habits and spent more sedentary life-style and were more careless about their health compared to their counterparts.

In addition, diet and nutritional habits had significant and positive relationship with exercise and physical activity ($r = 0.49, p < .01$). Students with healthy eating habits were physically more active and made good use of their leisure time compared to those less conscious about their diet and nutrition. Furthermore, the association between health consciousness and health carelessness (dimensions of health care) among them was found to be significant and positive ($r = -0.28, p < .05$).

CONCLUSION

It was concluded that knowledge (in terms of meaning/understanding, symptoms) about life-style related chronic diseases among school-going adolescents was inadequate in general, and about the behavioural and risk factors associated with chronic conditions like diabetes, hypertension, asthma and heart diseases in particular. Adolescent girls had relatively unhealthier dietary and exercise habits than boys. A significant positive association existed between knowledge about diseases and health behaviour (dietary habits, physical activity / exercise and health consciousness). Nutrition, dietary habits and sedentary life are closely related with most of the life-style related diseases as well as QOL. Healthy dietary habits and regular physical activities/exercise may effectively prevent life-style related diseases and are an important factor in public health promotion. Life-style diseases are the direct result of human behaviour, and adolescence is a timely period to shape and consolidate health enhancing behaviour. Life-style linked habits and practices are modifiable. In this context Social-Cognitive Theory is relevant to show how socio-cognitive variables affect individuals' behaviour patterns. It provides a framework which has widely been applied for prevention, health promotion and modification of risk behaviours. In sum, promoting healthy behaviour during adolescence will not only impact the development of healthy adult life, but also help to reduce the increasing risk of morbidity and mortality from life-style related diseases. Findings underlined the need to disseminate health knowledge at community and school level, and create an environment to motivate preventive behaviour among adolescents to lead a longer healthy life.

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FAMILY ENVIRONMENT IN RELATION TO EMOTIONAL INTELLIGENCE AND PERSONALITY

Ranjana*

ABSTRACT

In order to explain the influences of family environment on the development of personality traits, and emotional intelligence, the study was conducted on 200 students. The sample was drawn from different colleges of kurukshetra district of haryana. The participants were investigated using Family Environment Scale (Moos and Moos, 1981), Multidimensional Measure of Emotional Intelligence (Darolia 2003) and Neo- Five Factor Inventory (Costa, McCrae, 1991). The intercorrelation matrix revealed 42 significant correlations (35 positive and 7 negative) out of total 100 correlations. None of the measures of family environment shared any significant relationship with agreeableness dimension of personality. The findings of the study suggests strong relationships between different family environment dimensions with the Big Five personality factors and emotional intelligence and support family environment as a significant predictor of the Big Five personality dimensions and emotional intelligence. Therefore, it seems plausible that strategies enhancing the cohesive, encouraging and supportive family environment may play great role in shaping well adjusted personalities.

Keywords: Personality, Family environment and Emotional intelligence

Family relationships play an important role in an individual's life pattern from early childhood through adulthood. Much of an individual's personality patterning originates at home. Not only does the child inherit certain family potentialities, but during his developing years, his attitudes, beliefs, ideals and overt behavior reflects the influences on him of home experiences. Researchers typically separate elements of the home environment into two major categories; social and physical (Casy, Bradley, Nelson & Whaley, 1988; Wachs, 1989). According to Scott, "the

* Assistant Professor, Department of Psychology, Kurukshetra University, Kurukshetra

most important function of modern family life is psychological in nature." In families situations are provided setting the stimulation and guidance which determine, very largely, whether the child shall develop into a well-adjusted personality and socially useful individual. Family environment plays a significant role in the personality development and emotional intelligence of children. As the family environment influences personality, it also influences the emotional intelligence of the children similarly There are many psychological needs of the infant which must be met if he is to develop as an emotionally mature and socially well adjusted individual. Just as nourishing food and appropriate hygienic conditions are essential to satisfactory physical health and development; healthy psychological experiences are imperative to adequate personality development. Family is the first place where child's physiological and psychological needs are looked after. Family affects every area of a child's life. As a social unit with genetic, emotional, and legal dimensions, the family can foster the child's growth development, health and well-being. Family environment is the most important institution for the existence and continuance of human life and the development of personality traits. Families provide social and emotional supports that help family members cope with crises. Home provides the basic environment for building the personality of the individual with its warm interpersonal relationship contributing to their feeling of security and belongingness.

Emotional intelligence is the efficiency of a person to deal with emotions effectively (Bharadwaj & Sharma, 1995). It helps the individual to perceive, understand regulate and harness emotions adaptively in interpersonal relationships (Fitness, 2001). While parents' interaction with child and their form of attachment affect the emotional intelligence of child, home environment can be seen as a natural environment for the constitution of emotions and emotional attachments (Raikes, & Thompson, 2006). According to the study by Chen et al., (2005) parents with supportive attitude arrange home environment in such a way that it enhances emotional sufficiency of children. Mayer and Salovey (1995) have defined the emotional intelligence as "perceiving emotions, using emotions in order to support ideas, understanding emotions and emotional information, adjusting emotions for emotional and mental development". Recently two conceptions of emotional intelligence (trait emotional intelligence and ability EI) have been indicated. Trait EI (or trait emotional self-efficacy) concerns emotion related dispositions and self-perceptions measured via self-report, whereas ability EI (or cognitive emotional ability) concerns emotion-related cognitive abilities measured via performance based tests (Petrides et al., 2007). Family is the first environment where child feels, observes and learns the emotional relationships (Warhol, 1998). Several factors affect the development of emotional intelligence, Family environment is especially the most important one among these (Cole, Martin, & Denis, 2004; Parke, 1994; Walden & Smith, 1997). According to Morris et al.

(2007) family environment affects children's emotional intelligence in three aspects. Firstly children learn emotions by observing the people around them. Secondly their experiences and behaviours related to parent's emotions ensure children to become appropriate to society's expectations. Thirdly factors reflecting the emotional status of family such as the quality of emotional attachment between the child and the parents, attitude of parents, emotional and social openness, and marital relationship have impacts on emotional intelligence Kaur et al. (2005) studied the relationship between strategic emotional intelligence and family climate of Punjabi adolescents. Significant relationship was found between high performers for strategic EI and family climate. Ozabaci (2006) conducted a study to examine the relationship between EQ and family environment. The results of the study indicate that there was a relationship between EQ and family cooperation.

"Personality is the dynamic organization within the individual of those psychophysical systems that determine his characteristic behaviour and thought" Allport (1961). Personality is the sum of biologically based and learnt behaviour which form the person's unique responses to environmental stimuli. Carver & Scheier (2000) suggest that the word personality conveys a sense of consistency, internal causality, and personal distinctiveness. They defined personality as "Personality is a dynamic organization, inside the person of psychophysical systems that create a person's characteristic patterns of behaviour, thought and feeling."

Personality is also a cardinal factor which is responsible for the development of high emotional intelligence among the children. Researches show that there is significant difference in the emotional intelligence of extrovert and introvert. Emotional stability is more in extrovert than introvert (H. S & Betsur, 2010). The emotional atmosphere of the family, the way in which parents train their children and the opportunities and demands family life presents for normal development are present from early life, continue their influence in adolescence and shape the future course of adolescents' lives. The purpose is to modify the behavior of the child and to shape his personality in a desirable way in an effective way so that our children can have a sound personality NICHD Early Child Care Research Network, 1998) studied more than one thousand children of United States from ten different cities who were raised at home and some attended daycare centers for varied amounts of time. The main result was that the family had the most important influence on the three-year-old child's personality and character. Ribble (1943) revealed that physical warmth and affection, intelligently expressed by the mother is essential to satisfactory personality adjustment of the child. Parish, Dostal & Parish (1981) stated that the environment of the home in which a child is reared can advance or hinder wholesome personality adjustment Melvill (1977) thought that the type of family in which children are raised will determine, to a large extent, the number and types of social relationships that they will experience.

These relationships, in turn, will affect both personality development and social behavior. Nakao et al., (2000) studied the effects of family environment on personality traits. They found out that introverted children with high level of cognitive intelligence are influenced more by the family environment compared to extroverted children with low intelligence.

Jacob et al. (2010) examined a study related to personality and environmental concern. Structural equation modeling revealed that greater environmental concern was related to higher levels of the Big Five personality traits of agreeableness and openness. Both agreeableness and openness were related to the higher-order personal value of self-transcendence, reflecting an expanded sense of self and greater concern for others, the effect of neuroticism, with more neurotic individuals demonstrating significantly higher level of environmental concern. Other finding was that conscientiousness had a small but significant positive relationship with environmental concern.

Corrine et al. (2007) conducted a study on childhood experiences of physical punishment as related to perception of family environment during childhood and affective and personality outcomes of college students. Results suggest that experiencing physical discipline as a child may be related to one's family environment, personality and psychological well-being in young adulthood.

Susan et al. (1990) investigated the association between family environmental characteristics and the psychological characteristics of bulimia nervosa. Results showed that a restrictive and conflicting family environment high in parental control was associated with neuroticism and introversion. A second correlation showed an association between a stimulating, achievement-oriented family environment and extroversion. Stott (1939) studied the relationship between personality adjustment and family situations of children from varying environments. He found a marked tendency for those from sociable homes, to be well-adjusted personally and socially successful.

Conclusively, No other factor influences children as deeply as their families. As a social unit with genetic, emotional and legal dimensions, the family can foster the child's growth, development, health and well-being. The family can provide the child with affection, a sense of belonging, and validation, every area of child's life is affected by the family and its environment. Personality is assumed on the basis of individuality, consistency and changeable characteristics of behaviour. Family environment plays a significant role in the personality development of children. Developmental psychologists have been interested in knowing how family environment influences the development of different competencies among children. Keeping in view the above indication present studies have been incorporated to explore the influence of family environment on personality and emotional intelligence.

Objectives

Main objectives of the study are:

- 1 To examine the influence of family environment on personality.
- 2 To examine the influence of family environment on emotional intelligence.

METHOD

Sample

A sample of 200 students was randomly drawn from different colleges of Kurukshetra, district of Haryana. The age of the participants ranged from 17 to 21 years with the mean age of 19 years.

Measures

Family Environment Scale: The family environment scale was developed by Moos and Moos (1981). The FES is composed of 10 subscales that measure the actual, preferred and expected social environment of families. These 10 subscales assess three underlying sets of dimensions: relationships, personal growth and system and maintenance dimensions. The relationships and system maintenance primarily reflect internal family functioning, whereas the personal growth dimensions primarily reflect the linkages between the family and the larger social context.

The relationship dimensions of the scales are measured by the Cohesion, expressiveness and conflict subscales. The personal growth dimensions are measured by the independence, achievement orientation, intellectual-cultural, active-recreational orientation and moral religious emphasis subscales. The system maintenance dimensions are measured by the organization and control subscales. Mind Garden has provided a scoring key. To determine a persons' raw scores, number of responses given in the keyed declaim as identified on the scoring key for each subscale are counted and the total of each sub scale is entered in Raw Score box. Studies have found the scale to be reliable and valid measure. The split half reliabilities of subscales found to be ranging from 0.53 to 0.84. Construct validities have also been found to be satisfactory ranging from 0.67 to 0.85.

Multidimensional Measure of Emotional Intelligence (MMEI) (Darolia 2003): The MMEI is based on Goleman's (1995) model of emotional intelligence and taps five broad dimensions –self-awareness, managing emotions, motivating oneself, empathy, and handling relationships. The measure comprises of 80 items, 16 items for each dimension. Each item is answered on a five-point scale, viz. very true, mostly true, somewhat true, mostly false, and very false. The test can conveniently be administered as an individual test, as self-administered, or as a group test. The administration of MMEI takes about 25 to 35 minutes. The scale has been standardized for general adult population. The obtained scores, on

individual dimensions as well as on full scale, can be interpreted in terms percentile positions. The percentile norms for two age categories, 16 to 25 years and 26 to 45 years are given. The reliability indices for the MMEI are fairly high. The coefficient alpha ranged between .76 and .81 (N=415). The test-retest coefficients ranged between .79 and .84. With a time gap of 40 days (N=415). The construct validities of the five scales range from .68 to .76.

Neo-five Factor Inventory (Costa, McCrae 1992): NEO-Five Factor Inventory (NEO-FFI) is a 60 item version of the NEO-PI-R that is scored on the five domains only. The full NEO-PI-R form-S provides comprehensive study of Big Five factors - Neuroticism, Extraversion, Openness to experience, Agreeableness and Conscientiousness. It comprises of 12 items for each dimension, making a total of 60 items. Each item is responded by the subject on a five point scale represented by labels of strongly disagree, disagree, neutral, agree, strongly agree. There are some negative items, scoring of which was done in reversed manner. The alpha coefficients for the individual facet scale range from (.56) to (.81). The full scale coefficient alphas ranged from (.86) to (.92) (Costa et al., 1991). The test retest reliability (with three months interval) of NEO-FFI scale were obtained from a college sample, found to be (.79), (.79), (.81), (.75) and (.83) for N,E,O,A and C scales respectively.

RESULT AND DISCUSSION

SPSS software was used for statistical analysis. Correlation analysis was used for analysis of the data. The correlation analysis reveals that cohesion dimension of family environment correlated positively and significantly with self-awareness, managing emotions, motivating oneself and handling relationships, emotional intelligence and inversely correlated with neuroticism and positively with extroversion. This result indicates that a family environment promoting commitment, help and support for each other, enhances observation and recognition of feeling, appropriate handling of fear, anxieties and sadness, proper channeling of emotions, emotional self control and proper management of emotions among family members.

Such individuals do not experience negative effects like fear, sadness and are sociable, assertive, cheerful, energetic and optimistic and have interesting enterprising occupations.

Expressiveness demonstrated positive and significant correlations with self-awareness, motivating oneself and handling relationships. This indicates that family environment promoting open and direct expression of feelings, enhances proper observation and recognition of feelings, and appropriate handling of emotions like sadness, anger and anxieties among family members. These individuals can manage emotions competently and are socially skilled.

Correlation between family environment, emotional intelligence and personality (N=200)

Correlation between family environment, emotional intelligence and personality (N=200)

	SA	ME	MO	EM	HR	NEUROTICISM	EXTROVERSION	OPENNESS	AGREEABLENESS	CONSCIENTIOUSNESS
COH	.291(**)	.152(*)	.267(**)	.075	.311(**)	-.232(**)	.165(*)	.092	.119	.123
EX	.241(**)	.113	.234(**)	.077	.227(**)	-.087	.064	.043	-.048	-.028
CON	-.294(**)	-.229(**)	-.137	-.212(**)	-.331(**)	.255(**)	-.103	-.006	-.123	.018
IND	.138	.082	.104	.214(**)	.216(**)	-.227(**)	.173(*)	.132	.038	.094
AO	.170(*)	.048	.166(*)	.094	.148(*)	-.060	.214(**)	.207(**)	.053	.097
ICO	.046	.253(**)	.137	.146(*)	.172(*)	-.024	.162(*)	.192(**)	.052	.244(**)
ARO	.132	.234(**)	.141(*)	.098	.232(**)	-.204(**)	.156(*)	.164(*)	.069	.228(**)
MRE	.133	-.062	.195(**)	.142(*)	.087	-.113	.133	.132	.052	.117
ORG	.033	-.012	.280(**)	.084	.117	-.128	.096	.070	.090	.216(**)
CTL	-.038	.071	.038	-.133	.056	-.061	.201(**)	.009	-.088	.181(*)

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Conflict demonstrated negative correlations with self awareness, managing emotions, empathy and handling relationship dimensions of emotional intelligence and a positive relationship with neuroticism dimension of personality, indicating that conflicting family environment where members openly express aggression they do not exhibit emotional intelligence. They are not able to recognize and handle their fears, anxieties and sadness properly. They are impulsive and emotionally uncontrolled and do not possess social skills and competence. These individuals have a tendency to experience negative effects like guilt, embarrassment and disgust in their personality characteristics.

Independence correlated positively with empathy, handling relationships and extraversion but inversely with neuroticism. This result indicates that family environment where members are assertive and self sufficient in making their own decisions, such individuals are sympathetic, sensitive towards other's feeling can manage emotions, are also socially skilled and competent in their emotional intelligence. These individuals are social, assertive, energetic, and optimistic and like excitement and stimulation while not experiencing negative effects like fear, anger and sadness in their personality traits.

Achievement orientation demonstrated positive correlations with self awareness, motivating oneself, handling relationships, extraversion and openness to experience, indicating that achievement oriented and competitive family environment promotes self awareness, emotional self control, social skills and competence in the management of emotions in their family members. Individuals belonging to such family environment are social, active, cheerful, optimistic, aesthetic, imaginative, intellectually curious and make judgments independently.

Intelligence cultural orientation demonstrated significant and positive correlations with managing emotions, empathy, and handling relationships of emotional intelligence and extraversion, Openness to experience and conscientiousness of personality. It clearly indicates that family environment promoting interest in political, social, intellectual and cultural activities also promotes appropriate handling of emotions, sensitivity, management of emotions and social competence. Such individuals exhibit assertion, sociability, excitement and stimulation. These individuals also display active imagination, intellectual curiosity, independence in judgment, self control, impulse control and active and organized planning in their personality dispositions.

Active recreational orientation indicated positive correlations with managing emotions, motivating oneself and handling relationships of emotional intelligence and extraversion, openness to experience, conscientiousness and an inverse relationship with neuroticism of personality. This result indicates that family environment promoting participation in social and recreational activities also promotes appropriate handling of emotions, emotional self control, delay gratification of impulses, and social competence in emotional regulation. Such

individuals also display assertion, energy, optimism, active imagination intellectual curiosity, independent judgement, self and impulse control and active and organized planning and do not possess the general tendency to experience negative emotions like fear, anger and disgust in their personality traits.

Moral religious emphasis demonstrated positive correlations with motivating oneself and empathy, indicating that family environment emphasizing ethical and religious issues and values promote channeling of emotions, emotional self control, delayed gratification of impulses, sensitivity towards others feelings and appreciating difference of opinion among their members. It did not demonstrate any significant correlations with personality.

Organization displayed positive relationship with motivating one self and conscientiousness, indicating that family environment having clear organization and structure in planning family activities and responsibilities, promotes proper channeling of emotions, emotional self control, active planning and organized impulse control among their members.

Control demonstrated positive correlation with extraversion and conscientiousness, indicating that family environment where rules and procedures are set to run family life, enhances sociability, assertion, optimism, interest in enterprising occupations, self control and active planning and organization in impulse control in personality. None of the measures of emotional intelligence demonstrated any significant correlation with control dimension of family environment.

These results are supported by following studies: Devi et. al. (2004) examined the relationship between adolescent's perception about family-environment and emotional intelligence. Results of the study revealed that 4 out of 8 dimensions of family environment, cohesion, expressiveness, acceptance and caring and active recreational orientation were positively and significantly related to total emotional intelligence (EI) of adolescents. Chaturvedi et al. (2010) explored the relationship between emotional intelligence (EI) and dimensions of family environment. The finding revealed that CO, EX, Con, IND, ICO, ARO, MRE and ORG were significantly correlated with various domains as well as overall EI. It is concluded that family environment plays a significant role in the development of emotional intelligence.

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ANALYSIS OF EXECUTIVE FUNCTIONS IN CHILDREN WITH LEARNING DISORDER

Nice Mary Francis

ABSTRACT

This article examines executive functioning in children with specific developmental disorders of scholastic skills as defined by ICD-10. Eighty (40 LD Vs non-LD) second to fourth graders with a minimum IQ of 80 are compared. An extensive test battery assessed working memory, sustained attention, phonemic fluency and cognitive flexibility which are the four subcomponents of executive functioning described by Denckla (1996). Children with learning disability show deficits in visual-spatial memory; visual memory; cognitive flexibility, and sustained attention. Linear discriminant analysis using executive variables correctly classified 95% of the participants in both groups and these variables were: Verbal memory and sustained attention. It was concluded that verbal working memory is the most important neuropsychological correlates of learning disability.

Keywords: Learning disability, Developmental disorders and Neuropsychological correlates

The term 'learning disability' has been applied in those situations, where child has significantly greater difficulty in learning than the majority of his/her age. "Learning disability is a generic term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning or mathematical abilities. These disorders are intrinsic to the individual and presumed to be due to central nervous system dysfunction. Even though a Learning Disability may occur concomitantly with other handicapping conditions, or environmental influences, it is not the direct result of those conditions or influence" (IDEA 1981). According to Lerner (1993) prevalence estimates for LD have varied from as low as 1% to as high as 30% of the school-age population. A prevalence rate of 6% has also been reported

* Asst Professor, Dept of Psychology, Prajyoti Niketan College, Pudukad, Thrissur.
nicemaryfrancis@gmail.com Ph:9447250493

Indian Schools. In the Indian context, prevalence estimates range from 9 to 39 percent (Agarwal, Upadhyay & Singh, 1991).

Neuropsychological Parameters-Executive Functions

Neuropsychology is the study of brain behaviour relationships. It is based on the idea that the brain, working as an interdependent, systemic network, controls and is all inclusively responsible for behavior. In a recent definition by Roberts and Pennington (1996), executive functions were described as "a collection of related but somewhat distinct abilities such as planning, set maintenance, impulse control, working memory and attentional control". This indicates that "executive functions" refers to a system of multifactorial functions. Executive functions have been operationally defined as those higher order control processes that regulate cognition during tasks such as writing, reading, etc. Denckla (1996) proposed a conceptual model of executive functioning comprising of four key domains of functions, viz., initiating behaviour, sustaining behaviour, inhibiting/stopping behaviour and set shifting. Given this model, the following components of executive functions were selected: initiation, set shifting, sustaining and inhibition/stopping. To measure these executive function domains, three tasks were selected across the four target domains. They are working memory tasks, tasks related to attention sustaining and test of phonemic fluency.

Objective

The objective of the study was to assess the differences between learning-disabled children and matched non-disabled children in terms of certain selected neuropsychological executive variables (sustained attention, verbal fluency, cognitive flexibility, working memory)

The Hypotheses

Learning disabled children and control group children would differ on the selected variables of executive functions, viz., (1) Sustained Attention (2) Verbal Fluency (3) Cognitive Flexibility (4) Working Memory

METHOD

Sample

The sample for the study consisted of two groups, viz., learning disabled group (LD group), and the control group (non- LD group). The children were diagnosed as having learning disabilities (reading, writing, arithmetic, mixed) according to the ICD -10(WHO,1992) classification and the clinical diagnosis was made by the clinical psychologist /psychiatrist working in the mental health centre from where the learning disabled sample was selected. Their age group is between 9 to 15 years and they were attending regular school where the syllabus was State, CBSE or, ICSE. A sample of 40 LD children was selected on the basis of the above criteria who were attending the learning disability clinic in the Mental

Health Centers located in Ernakulam town. Of the total of 40, 28 were males and 12 were females. A sample of 40 normal children who are matched with the study (LD) group in respect to age, class, sex, birth order, religion, and medium of instruction were selected to serve as a control group in the study. The students were selected from the 3 schools situated in Ernakulam district, Kerala.

Tools

The following psychological measuring devices were used in the present study.

- 1) **Colour Cancellation Test (Kapur, 1974):** Colour Cancellation Test is a measure of sustained attention. Subjects are required to cancel out the red and yellow circles as far as possible. Time taken to complete the test is recorded and errors of omissions and commissions are noted.
- 2) **FAS Phonemic Fluency Test (Lezak, 1995):** FAS phonemic Fluency Test is a measure of verbal fluency. This test evaluates spontaneous production of words beginning with a given letter, within a limited time.
- 3) **Colour Trails Test - Trail B (D'Elia et al., 1996):** Colour Trails Test - Trail B is a measure of mental or conceptual tracking and cognitive flexibility. The subject is required to connect the numbers serially from 1 to 25 alternating between pink and yellow circles and disregarding the number in circles of the alternate colour. Time taken for trail B is noted and errors are also recorded.
- 4) **N Back Task (Smith & Jonides, 1995):** N Back Task (Verbal) is a measure of verbal working memory. It consists of a '1 back task' and a '2 back task'. The subject is required to respond in terms of 'Yes' or 'NO' for phonetically similar and dissimilar sounds respectively. The subject has to say 'yes' for each consecutively repeated sound and 'NO' for the other sounds.
- 5) **Visuospatial Working Memory Span Task (Milner, 1971):** This test is a measure of visuospatial working memory span. The subject is required to repeat the sequence of four taps tapped by the examiner. Five trials of forward and five trials of reverse sequences are given. Number of correct sequences tapped by the subject for both the forward and reverse conditions together comprises the total score for this test.

RESULT AND DISCUSSION

To test the tenability of the various hypotheses formulated for the study, the data were subjected to inferential statistical procedures.

Table 1: Mean and SD of the scores on Colour Cancellation Test obtained by the two groups and significance of differences between the means

<i>Variable</i>	<i>Group</i>	<i>Mean</i>	<i>SD</i>	<i>t-value</i>	<i>Sig</i>
Colour Cancellation	Learning Disabled	86.40	25.117	5.100	.000
Test Time score	Normal	63.18	14.097		
Colour Cancellation	Learning Disabled	1.25	1.428	1.067	.289
Test Error score	Normal	.95	1.061		

Sustained Attention

As indicated in Table 1 mean score shows that the performance of the LD group was lower than that of the control group in both the time taken to complete the task and the number of errors made in the task.

In the colour cancellation task attention must be maintained over long periods of time, in order to detect a singular stimulus that occurs randomly and infrequently over time. Douglas (1974) had suggested earlier that attention problem in LD children stems from two problems, viz., (1) the inability to sustain attention and (2) the inability to control impulses.

However present results show that the LD students could not sustain attention (significantly higher mean score of LD group of time score) while there was no difference in the error scores of the two groups.

Verbal Fluency

From the Table 2, it is apparent that the number of mean words produced by the control group was 28.42, while the mean score of the LD group was 20.15. The performance of the LD group on the verbal fluency task was significantly as lower compared to the control group and needed further explanations.

Table 2: Mean and SD of the scores on Phonemic Fluency Test obtained by the two groups and significance of difference between the means

<i>Variable</i>	<i>Group</i>	<i>Mean</i>	<i>SD</i>	<i>t-value</i>	<i>Sig</i>
Phonemic Fluency	Learning Disabled	20.15	7.618	4.692	.000
	Normal	28.42	8.149		

The detrimental performance in phonemic fluency could be explained in the context of "phonological deficit hypothesis", which is the most widely accepted hypothesis with respect to the cognitive origin of dyslexia (Stanovich, 1998). According to this hypothesis, reading disabilities arise from basic deficiencies in the ability to generate and maintain phonological representations in working memory, but not from deficiencies in other cognitive domains. The results of

this study support the above hypothesis, that when the LD group was compared to a matched-group performance of significant deficiencies were observed in phonemic fluency domain of phonological process.

Cognitive Flexibility

Examination of the mean scores reveals that the LD group took longer time ($M=160.38$; $SD=58.297$) to complete the task as compared to the control group ($M=98.42$; $SD=28.072$). This indicates that the LD group is lower in cognitive flexibility compared to the control group.

Table 3: Test–Trail obtained by the two groups and significance of difference between the means

<i>Variable</i>	<i>Group</i>	<i>Mean</i>	<i>SD</i>	<i>t-value</i>	<i>Sig</i>
Colour Trails	Learning Disabled	160.38	58.297	6.055	.000
Test-Trail B Time	Normal	98.42	28.072		
Colour Trails	Learning Disabled	1.30	1.159	1.640	.105($p>.0$)
Test-Trail B Error	Normal	.88	1.159		

In their study Krishna et al. (1982), found that 56% of children with learning disability showed some deficits in the Part B of the Trail Making Test. The result of the present study is consistent with that of Krishna et al. Significantly more time was taken by the LD group in completing the task thereby indicating that there is a general slowing of mental processing and mental tracking among the LD group. However here again no difference was observed in the error scores.

Working Memory

Working Memory was measured in both verbal and visuospatial modalities. The Nback tests (verbal 1back and verbal 2back) were used to assess verbal working memory while the tapping tests (forward and backward) were used to assess the visuospatial working memory. The mean scores obtained by the learning disabled and the control group on each of these tests were compared using t-tests and the results are presented in table 4 and 5.

Verbal Working Memory: The t-test was carried out to compare the LD group and control group in terms of their scores, on the task. The t-value presented in the table 3.1 shows that there is significant difference between the two groups in both the 1 N back (t value = -3.042; $P < .003$) and the 2 N back (t -value = 11.251; $P < .001$). Examination of the mean scores presented in the same table indicates that children with learning disabilities did perform lower than the controls on both these tasks.

Table 4: Mean and SD of the scores on Verbal working memory test obtained by the different subgroups and the t-values.

<i>Variable</i>	<i>Group</i>	<i>Mean</i>	<i>SD</i>	<i>t-value</i>	<i>Sig</i>
NBACK 1 Score	Learning Disabled	5.75	1.256	3.042	.003
	Normal	6.68	1.457		
NBACK 2 Score	Learning Disabled	2.58	1.318	11.251	.000
	Normal	5.80	1.244		

The results are consistent with the findings of Jeffries and Everett (2003) that children with LD especially those with reading disabilities have impairments on verbal working memory. With regard to working memory, which is one of the most extensively studied aspect of executive functioning, a number of studies have demonstrated that verbal working memory in children with dyslexia is disturbed in comparison to that of the non-dyslexic children (Baddeley, 1986; Jeffries & Everatt, 2004). Verbal working memory has three important components i.e., storage, manipulation of information and rehearsal. N back task is based on the premise that two variables can affect verbal working memory i.e., word length and phonemic similarity. Jorm (1983) has suggested that children with reading disability are not able to rehearse the verbal material sub vocally as effectively as controls. The present study result is also consistent with the above finding that the phonological loop might be impaired due to a malfunctioning sub vocal rehearsal mechanism in LD children. If the words are more in number the rehearsal mechanism will be in danger in learning disability group. The present result illustrates the lower performance of LD children in N-back task and that may be due to word similarity effect or due to the problems in subvocal rehearsal system.

Visuo-spatial working memory: From the table 5 it is clear that, in all the three measures of this task the performance of the study group children was lower as compared to the control group.

Table 5: Mean and SD of the scores on Visuo-spatial working memory test obtained by the two groups and significance of differences between the means.

<i>Variable</i>	<i>Group</i>	<i>Mean</i>	<i>SD</i>	<i>t-value</i>	<i>Sig</i>
VSWM Forward	Learning Disabled	4.12	1.067	3.829	.000
	Normal	4.82	.446		
VSWM Backward	Learning Disabled	2.62	1.005	5.415	.000
	Normal	3.78	.891		
VSWM Total	Learning Disabled	6.75	1.736	5.721	.000
	Normal	8.60	1.081		

The hypothesis stating that children with LD and controls would differ on the visual-spatial working memory tasks was supported. Their performance was differentially lower as compared to controls when engaged in both backward and

forward sequence indicating deficits in both active as well as passive visuo-spatial components of working memory. These results receive support from those of Cantor, et al (1991) who found that young adolescents with non-verbal LD and low visuo-spatial intelligence presented marked deficits in a series of visuo-spatial working memory tasks. To explain these deficits they proposed a model of visuo-spatial working memory that distinguished between passive and active visuo-spatial components. Visuo-spatial working memory deficits in children with low visuo-spatial intelligence seem to involve not only the passive, but also the active components of the system.

Discriminant Function based on Executive Function Variables

Discriminant function analysis was conducted using the executive function variables included in the study in order to find out the most important parameter which could be used to discriminate between the LD group and non-LD groups. The results of the analysis showed that a combination of two tests could differentiate between the two groups with 95% accuracy. These variables were Verbal 2 Back Tests and Colour Trails 'B' error score.

Theoretical Implications: The finding from multivariate analysis is of very high practical importance, because of the fact that it points towards the possibility of identifying some key neuropsychological functions which can be used to discriminate between the learning disabled and the control groups. As per the results of the present study it may conclude that cognitive flexibility and active verbal working memory the most important neuropsychological correlates of learning disability.

Practical Implications: Deficits in the neuropsychological function of learning disabled children, especially in the components of memory, calls for remedial retraining strategies in the areas of weakness identified. Deployment of trained personnel (preferably those who have got special training in the identification and management of learning disability) at the primary school level may be helpful in the early identification of children at risk and to initiate remedial measures early enough.

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EMOTIONAL INSTABILITY, EMOTIONAL-REGRESSION AND SOCIAL MALADJUSTMENT OF ADOLESCENT GIRLS HAVING EXPERIENCE

Zeba Qamar

ABSTRACT

The study was aimed to study the impact of sexual abuse on emotional-unstability, emotional-regression and social maladjustment of adolescent girls. In order to achieve the objective of the study a total of 60 school going adolescent girls were selected. Out of 60 girls' 30 girls were those who reported severely sexual abuse in their childhood and 30 were moderately sexually abused girls. Emotional maturity scale was administered to all the participants. In order to find out significance of difference between the two groups, t-test was used. The results of the study revealed that adolescents witnessing severe sexual abuse and adolescents witnessing moderate sexual abuse differed significantly on social maladjustment.

Keywords: Emotional-unstability, Emotional-regression and social maladjustment, Emotional maturity and Sexual abuse.

Child abuse is a state of emotional, physical, economic and sexual maltreatment meted out to a person below the age of eighteen and is a global prevalent phenomenon. However, in India, as in many other countries, there has been no understanding of the extent, magnitude and trends of the problem. The growing complexities of life and the dramatic changes brought about by socio-economic transitions in India have played a major role in increasing the vulnerability of children to various and newer forms of abuse. According to WHO: "Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust

* Research Scholar, Deptt. of Psychology, Kumaun University, SSJ Campus, Almora (Uttarakhand)

power." Child abuse is quite simple neglect by parents of their children. Maltreatment is also termed as child abuse. Child abuse may be sexual, physical or emotional in nature. Depending on various factors and situations, child abuse mars a child for life and may impede their progress and lifestyle.

According to USA Congress(1986): 'Child Abuse and Neglect means the physical or mental injury, sexual abuse and exploitation, negligent treatment, or maltreatment of a child under the age of 18'.

The Child Abuse Prevention and Treatment Act defines child abuse and neglect as: "at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm." David Gill(1968) has defined physical abuse as "any non-accident physical attack or physical injury, inflicted upon the child by the child's caretakers". According to the report published in 2005 on 'Trafficking in Women and Children in India', 44,476 children were reported missing in India, out of which 11,008 children continued to remain untraced."Child abuse" can be defined as causing or permitting any harmful or offensive contact on a child's body; and, any communication or transaction of any kind which humiliates, shames, or frightens the child. Some child development experts go a bit further, and define child abuse as any act or omission, which fails to nurture or in the upbringing of the children. According to Oates (1996), sexual abuse of children means involvement of dependent, developmentally immature children and adolescents in sexual activities, which they do not fully comprehend and to which they are unable to give informed consent. Sexual abuse includes touching, fondling and penetration.

Sexual abuse has a significant impact on the all-round development of the children. The effect of sexual abuse on children are: guilt, shame, fear, grief, anger, helplessness, depression, sleep disturbance, seductive behaviour, eating disorder, and allergies etc.

According to the National Committee for the Prevention of Child Abuse(NCPCA), sexually abuse constitute about 11 percent of cases reported, in 1995 almost 350,000 cases, currently, approximately one-third of reports are substantiated after investigations of Child Protection Services (CPS) i.e., about 110,000 of sexually abuse annually. Although the number of cases from the CPS report is considerable study of 1000 parents conducted by the Gallop Poll in 1995 yielded a projection 10 times larger, of one million children during the previous year Widom(1999) observe that 37.5 percent victims of childhood sexual abuse, 32.7 percent of childhood physical abuse and 30.6 percent of childhood neglect meet DSM-III R criteria for lifetime PTSD. Silber and Stock (1999) administered Appreciative Personality Test and Draw-A-Person Questionnaire among 163 females (16-50 years) who were sexually abused in childhood and 163(15-52 years) controls. Authors found abused more depressed, passive, hostile and less trusting than controls.

Crime Head Years % Variation in 2002, 2003, 2004, 2005, 2005 Over 20

1. Rape 2532 2949 3542 4026 13.7
2. Kidnapping & Abduction 2322 2571 3196 3518 10.1
3. Procurement of Minor Girls 124 171 205 145 29.3
4. Selling of Girls for Prostitution 5 36 19 50 163.2
5. Buying of Girls for Prostitution 9 24 21 28 33.3
6. Abetment of Suicide 24 25 33 43 30.3
7. Exposure and Abandonment 644 722 715 933 30.5
8. Infanticide 115 103 102 108 5.9
9. Foeticide 84 57 86 86 0
10. Child Marriage Restraint Act 113 63 93 122 31.2
- TOTAL 5972 11633 14423 14975 3.8

Keeping in view of the above discussion it was considered to explore emotional-unstability, emotional-regression and social-maladjustment of those girls who have experienced sexual abuse during their childhood.

METHOD

Sample

The present investigation was conducted on a sample of 60 adolescent girls. The sample is divided into two groups 30 severely abused adolescent girls and 30 moderately abused girls. All the subjects were drawn from Delhi.

Tools

Emotional maturity scale (EMS) was used to measure the emotional maturity. Emotional maturity scale has a total of 48 items. Only three factors, namely emotional-unstability, emotional-regression and social-maladjustment of emotional maturity scale were measured.

RESULT AND DISCUSSION

It may be recalled that study was designed to investigate difference between severely sexually abused and moderately abused adolescent girls. In order to find the significance of difference between severely sexually abused and moderately abused subjects on emotional maturity scale, t-test was used.

Table-1: Mean, and t-value of moderately abused and severely abused for dimensions of emotional maturity.

<i>Dimensions</i>	<i>Moderately Abused</i> <i>Mean</i>	<i>Severely Abused</i> <i>Mean</i>	<i>t-Value</i>
Emotional Instability	24.86	26.77	1.23
Emotional Regression	25.9	24.13	.79
Social Maladjustment	23.2	26.4	2.3**

**p>.05

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As evident from table 1 that the mean score of moderately abused subjects on emotional Unstability dimension of Emotional maturity scale is 24.8 and the mean score of severely abused subjects on Emotional Unstability dimension is 26.77. The difference between the two means is nonsignificant at 0.05 level of confidence ($t=1.23$, $p>0.05$).

The mean score of moderately abused subjects on Emotional Regression dimension of Emotional Maturity scale is 25.9 and the mean score of severely abused subjects on the same trait is 24.13. The difference between the two means is not significant beyond 0.05 level of confidence ($t=.79$, $P>0.05$).

The mean score of moderately abused subjects on Social Maladjustment dimension of Emotional Maturity scale is 23.2 and the mean score of severely abused subjects on Social Maladjustment trait is 26.4. The difference between the two means is significant beyond 0.05 level of confidence ($t=2.3$, $P<0.05$).

The findings of the study revealed significant difference between social-maladjustment dimension of emotional maturity of adolescents witnessing severe sexual abuse and moderate abuse. The mean scores obtained by both groups of subjects indicate that the social maladjustment of both groups of adolescents is low. Dillon (1999) conducted a case study with 19 year old girl who was sexually abused between ages 6 and 12 and got pregnant at the age of 16. She was tested on "Draw-A-Person Questionnaire", "Karp Objective Word Assessment Test" and the "Appreceptive Personality Test". The researchers concluded that the girl's responses reflected many problem, the most consistent being reflection of emotional immaturity and distorted use of sex. So the research is not similar to the studies.

We see that social-maladjustment of sexually abused girls is affected by the extent of the sexually abuse they have experienced. The experience of severe sexual abuse in the childhood stage caused social-maladjustment in the adolescent stage of girls. Sexually abused adolescent girl shows lack of social adaptability, seclusion, liar and shirker in their behaviour.

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AN INNOVATIVE BRIEF BEHAVIOUR TECHNOLOGY FOR EFFECTIVE MANAGEMENT OF GAY LESBIANS AND QUEERS

Prof. Dr. Vedagiri Ganesan

ABSTRACT

This paper describes a Brief Behaviour Technology (BBT) for the effective management of individuals, who need help for their 'Survival' as well as for their 'Option'. The BBT describes a well defined procedure that can effectively achieve within a short period the 'Reduction of the Rate of Breathing' that can be instrumental in redefining the Sexual Orientation of the Client. The Temporal Efficacy and the Guaranteed Cognitive and Behavioural Changes are assured. It is clear that only India can offer this Program due to Socio-Political and Professional reasons. Ethical considerations for Labeling and offering Professional Services are discussed. The possibility of the Extinction of the Human Species is indicated.

Key Words: Gays, Lesbians, Queers, Reorientation and Brief Behaviour Technology

Some Psychologists assume that Gays, Lesbians and Queers are caused by genetic factors. Hence they are considered to be not amenable for treatment.

But on the contrary, when in the above cases, when 'Behaviour-Change' is made possible it implies that the above assumption is a myth.

Diagnostic Statistical Manual (DSM) I, II, and III have classified Homosexual and Lesbians as Pathological, whereas DSM IV and V, have dropped them.

But the US Defense Services still follow the DSM III. It is considered illegal to treat Homosexual and Lesbians and those, who treat will be prosecuted. One can only sympathize with the people, who wish to take help in US or elsewhere in the World.

* Prof. Dr. Vedagiri Ganesan, Ph. D., Hon. Director, Global Institute of Behaviour Technology, P. B. No. 7301, Bharathiar University, Coimbatore - 641 046, and Ex. Professor & Head, Dept. of Psychology, Bharathiar University, Coimbatore India - 641 046, Ph: +91 9443478684 professorvg@yahoo.com

In some other Cultures and Nations it is legally permitted.

In certain other Cultures and Nations the above behaviours are severely punishable to the extent of life imprisonment or even death penalty.

Thirty-six countries including Afghanistan, Algeria, Bahrain, Bangladesh, Brunei, Djibouti, Egypt, Eritrea, Gambia, Guinea, Guinea Bissau, Indonesia, Kuwait, Lebanon, Libya, Maldives, Morocco, Oman, Qatar, Senegal, Sierra Leone, Sudan, Syria, Tanzania, Tunisia, Turkmenistan, and Uzbekistan with punishments including anything from a fine up to life imprisonment.

Ten of those countries out of the thirty-six impose the 'Death Penalty' for homosexuals. They are Iran, Mauritania, Nigeria, Pakistan, Saudi-Arabia, Somalia, Sudan, United Arab Emirates, Yemen and some states in Malaysia.

In eleven Countries, where same sex marriages are legal. They are Argentina, Belgium, Canada, Iceland, Mexico, Netherlands, Norway, Portugal, South Africa, Spain and Sweden.

India was among the 43 countries, who supported Russia's attempt to prevent staff benefits from being extended to gay couples.

UN Secretary-General Ban Ki-moon said in July 2014 that the United Nations would recognize all same-sex marriages of its staff, allowing them to receive UN benefits.

Previously, staff members' personal status was determined by the laws of their country of nationality. But the United Nations now recognises all same-sex couples married in a country, where it is legal, regardless of their nationality.

Russia wanted the 193-member General Assembly Fifth Committee, which deals with the UN budget, to overturn Ban's decision and had been threatening to put the measure to a vote since December 2014.

But the motion was overturned after the UN General Assembly budget committee voted 80 to 43 against the proposal.

There were 37 abstentions and 33 countries did not vote.

India voted to deny benefits to Gay UN staffers, in favor of Russia's proposal and the other countries, which joined the voting were Saudi Arabia, China, Iran, India, Egypt, Pakistan, and Syria.

The Supreme Court of India has established the Gays, Lesbians and Queers are punishable under the Indian Penal Code.

Under the above circumstances, the following Brief Behaviour

Technology has been developed.

Actual Causes for such Behaviours

The client at his or her very young age, when subjected to sexual abuse by an adult member of the opposite sex, develops a 'Phobic Response' to the members of the opposite sex.

When their sexual urge emerges in their adolescence, they emotionally and behaviourally lean towards the same sex members.

This same sex interest and behaviour gets strengthened through 'Habit Strength'.

Brief Behaviour Technology for Weakening the above Habit- Strength

The 'Hetero-Sexual-Phobia' as well as the 'Same-Sexual-Mania' can both be eradicated by the following Brief Behaviour Technology, which has the 'Temporal Efficacy' within a duration of ten days.

Arousals, either caused by Phobia or Mania alter the Breathing Rate. When the client is trained to significantly reduce the Breathing Rate, both the Phobia and Mania are extinguished.

The client is asked to keep counting continuously the Exhalations and Inhalations continuously for a period of one minute duration. For example, the count is 32, it can be divided by 2, which will give a product of 16. And this 16 is the 'Rate of Breathing'.

Ten trials are to be done in a session, with 'one-minute-rest' in between each trial.

The client is asked to deliberately and gradually to reduce their Breathing Rate, by prolonging the period of Exhalations and Inhalations.

As days progress, the client can reduce the Breathing Rate to just '1'.

At this stage, the client is exposed to ten photos of the same sex members in the increasing levels of nudity and arousal. The client is asked to bring down the Breathing Rate to just '1', even while looking at each of the photos.

The above procedure is to be repeated with exposure to ten photos of the opposite sex members.

Again the same procedure is to be repeated with exposure to ten photos of the heterosexuals in copulation.

Thus the 'Habit-Strength' can be extinguished and the 'Natural-Hetero Sexual-Response' can be established.

Benefits of this Technique:

1. The lives of lots of peoples with the above behaviours can be saved from social ostracism or punishment.
2. Their Families can accept them.
3. The Reproductive Cycle of these persons and families can be recovered
4. Negative Population Growth of a Nation can be arrested.
5. Racial Continuity and Propagation can be preserved and prevented from extinction.

ENHANCING EMOTIONAL INTELLIGENCE AMONG INDUSTRIAL WORKERS WITH THE APPLICATION OF BEHAVIOR TECHNOLOGY

R. Santhanakrishnan,*

ABSTRACT

The present study attempts to enhance the Emotional Intelligence (EI) of Industrial Workers. Many of the Industrial Workers have psychosomatic problems due to the emotional problems related to Anger, Anxiety, Depression, Sex etc. Enhancement of Emotional Intelligence is highly required for the Management of the above Emotions.

Key Words: Interventions techniques, Behaviour technique and Employee counselling

Aims of the Present Study

1. To measure the Emotional Intelligence among the Industrial Workers.
2. To administer Brief-Behaviour-Technologies for the Enhancement of Emotional Intelligence.
3. To evaluate the efficiency of the Brief-Behaviour-Technologies in the overall enhancement of the Emotional Intelligence.

METHOD

Sample

A sample of 51 workers from a large automobile ancillary parts manufacturing industry in Coimbatore was considered for this study. In order to enhance Emotional Intelligence, Interventions Techniques of Behaviour Technology was administered on the workers for one hour per day for six weeks.

* Doctoral Research Fellow, Texila American University, Guyana, South America.
D-2, Elysium Palacio Apts., 14, T. Krishnan Str, Peelamedu Pudur, Coimbatore
641038., tanasan09@gmail.com

Measures

Emotional Intelligence - Trait Emotional Intelligence Questionnaire
Behaviour Technologies Administered:

1. Anger Relaxation Technique (Ganesan, 1980)
2. Reduction of Breathing Rate (Ganesan, 1990a)
3. Ashwini Mudra Technique (Vethathiri Maharishi, 1972)
4. Simplified Kundalini Yoga (Vethathiri Maharishi 1972)
5. Maha Prana Dwani (Mahaprajna, 1995)
6. Laughter Technique (Ganesan 1990b)
7. Creativity/ Problem Solving Skill (Ganesan, 1985)
1. **Anger Relaxation Technique** is a very effective technique to control or reverse the anger. Aggressive Anger behaviour has been posed as a great threat to the development of the individual. This technique consists of a particular breathing pattern and skeleto-muscular reactions elicited along with the expression of the emotion of anger. When this technique is rehearsed in a controlled manner, it could help gain voluntary control of the Emotion of Anger.
2. **Reduction of Breathing Rate** is an effective way to reduce anger, tension and depression. The normal rate of one's breathing is from 12 to 20 per minute. By this Behaviour Technology Intervention one can reduce the breathing rate to 5 even lower. Lower the Breathing Rate, the better it is. This is done by sitting on a mat straight, back, neck and head in one vertical line, and count one's breathing, both exhalations and inhalations in a minute. The number of exhalations and inhalations are counted for one minute and it is divided by 2 which gives the number of Breaths per Minute.

After doing for one minute, relax for a minute, repeat the same procedure and count the number of breaths again, this time trying to breathe slowly. Thus 10 such counts shall be taken and the final value would be much lower than the first value. This technique may be repeated two or three times a day for a better effect.

Ashwini Mudra Technique is another Behaviour Technique intervened by Vethathiri Maharishi and is very effective for enhancing one's Emotional Intelligence. Ashwini means Horse and Mudra means Symbol or Posture. The horse is very fast, dynamic and its skin is always smooth and doesn't wrinkle. When it passes its motion, it repeatedly squeezes its anus muscles tightly and then releases. Ashwini Mudra got its name because the action of anal contraction resembles that of a horse with its anal sphincter immediately after evacuation of its bowels. This is a very powerful technique to pump the energy up into Maripura Chakra above.

This Mudra involves the contraction and relaxation of the buttock muscles, sphincter, perineum and the entire pelvic region. This can be practiced by pregnant women. Ashwini Mudra is also good for women in labour as it saves her from pain and fatigue. Since all the nervous system ends at the anus, this action triggers all the nerves and rejuvenates the whole body and the brain, enabling a better emotional health.

3. **Simplified Kundalini Yoga** by Maharishi Vethathiri is yet another important Behaviour Technology Intervention. This arouses the Kundalini Power from Mooladhara to the center of the eye brows, called Agna Chakra. This Enables the Respondent to feel the existence and function of the mystic Kundalini Power, that gives greater awareness of the Divine and continuous flow of Happiness and Joy. This also contributes to the enhancement of Emotional Intelligence and improves memory. This is done by Sitting straight, closing the eyes and concentrating on the midpoint of both the eye brows, which is called the Agna Chakra.

4. **Maha Prana Dwani** by Mahaprajna is also another Behaviour Technology Intervention technique that can be used to quieten the mind, reducing the mental frequency for Beta to Alpha and thereby improving ones' Emotional Intelligence. This is done by sitting straight on a mat, closing the eyes and chanting "Imm..." (Closing the mouth), for as long as possible after one long Inhalation. Again repeat the same for ten minutes and then relax for 15 minutes. This may be done twice a day morning and evening.

5. **Laughter Technique** by Ganesan is a very useful Behaviour Technology Intervention Technique that brings many positive results on the respondent who practices this intervention. Laughter brings lot of Psycho, Neuro and Endocrinological changes in the body. It increases the Oxygen intake, lungs muscles strengthens and body relaxes. Laughter has been proven to be an instant stress reliever. Laughter has become smarter way to relax, to beat the stress, tension and depression. The Emotional Intelligence increases in a person who practices this technique regularly.

This is done by sitting or lying down on a mat, taking a long breath and repeating the Tamil Language main Alphabets viz., Aa as Haa., Ee as Hiee., Oo as Hhoo..., Ae as Hhae..., Oo as Hhoo.... Once each of these alphabets are repeated in quick succession a number of times as stated, this becomes Laughter. Continue this laughter within the same breath so as to empty the lungs completely. End this by laughing out loudly and heartily.

6. **Creativity/ Problem Solving Skill** is one more Behaviour Technique Intervention technique that can be practiced to trigger the Right brain and activate it effectively. This involves in giving a Problem to the Respondents and asking them to write down different solutions to the

problem. There shall normally be more than one solution to the problem. Every other solution shall be of different nature or from a different angle. This enables lateral thinking and engages the active function of the right brain. This Creativity or Problem Solving Skill also enhances one's Emotional Intelligence. .

RESULT AND DISCUSSION

The "Before and After" measurements of Emotional Intelligence Scores are presented in Table-1 and the bar diagram is presented in Fig. 1 below.

TABLE – 1: Enhancement of Emotional Intelligence Among Industrial Workers (N = 51)

Emotional Intelligence	Mean (SD)	Mean Difference	Critical Ratio
Before Intervention	86.22 (26.54)	17.18	3.40**
After Intervention	103.40 (23.84)		

** $p < 0.05$

The results presented in Table 1 and Fig 1 clearly show that in the "Before-After-Conditions", the Emotional Intelligence Scores have significantly increased from M 86.22 to M 103.40, with a Mean Difference of 17.18, and a Critical Ratio of 3.40, significant at 0.05 level.

The results reported in this paper are a part of a larger study on Employee Counseling.

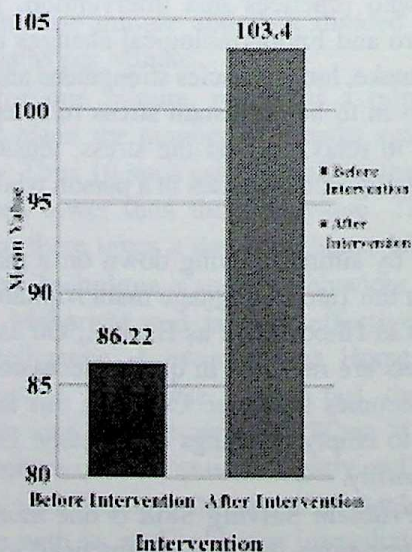


Chart 1. Enhancement of Emotional Intelligence

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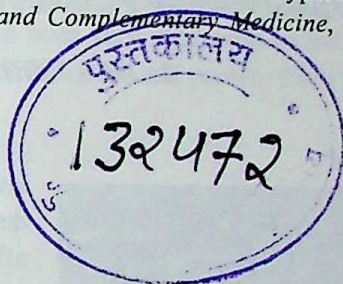
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CONCLUSION

Administration of Behaviour Technologies had significantly enhanced the Emotional Intelligence among the Industrial Workers.

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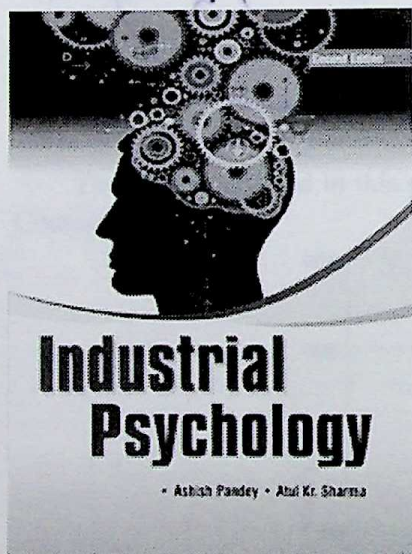
BOOK REVIEW

Industrial Psychology

Authored by: Pandey, A., & Sharma, A.K.

Global Academic Publishers & Distributors, New Delhi 2015

Rs 290/-, ISBN: 9789381695487



How does a person's skills, way of working duties and obligations associated with job affect his general job satisfaction on a day-to-day basis? What behaviours and attitudes influence job performance and how can they be improved through hiring practices, training programmes and feedback systems. These and other such highly relevant questions pertaining to human behaviour under industrial circumstances have been answered by Global academic publishers & distributors' second edition of Pandey and Sharma's Industrial Psychology (2015). The book offers an in-depth coverage of the basic issues of Industrial Psychology as well as its practical

applications in everyday life. With B.Tech and MBA students, in particular as its target readers, the book focuses on a wide range of topics which have broadly been divided into five units. Unit I deals with the core concepts of Industrial Psychology – from the concept and scope of Industrial Psychology to how research is conducted to generate answers. Unit II deals with topics like work motivation, satisfaction and stress management. Unit III focuses on the human side of Industrial Psychology with chapters on organizational culture, leadership

and group dynamics, whereas Unit IV is concerned with the aspects of the job such as job analysis, evaluation and compensation, recruitment, selection and retention and also performance appraisal and performance management. The final Unit V discusses topics like training and development, career development and employees relations management.

One of the main features of the book is that it extensively covers the current knowledge including basic historical reviews and further identifies practical issues and research trends in the field. The book has been written in an extremely lucid style which makes it eminently readable. Further, the main points have been highlighted and pertinent information has been presented through the use of numerous charts, tables and flow charts. These features will make it a text which is useful to all those concerned with industry and labour management.

The goal of the textbook has been to provide the reader with a well rounded understanding of the complexities of industrial environment and of human behaviour within them. The authors have been very successful in their attempt to simplify and succinctly state these intricate issues and present them in simple, elegant and interesting language.

Anjali Malik

Professor, Dept. of Psychology,
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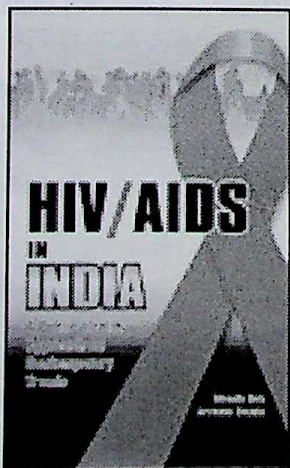
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Prof. Sibnath Deb is a senior faculty in the Department of Applied Psychology, Pondicherry University, Puducherry.

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EDITORIAL

The present issue of the Journal of Health Psychology has eleven papers, two short communications and a book review. All the research articles deal with variety of psychosocial issues in health and illness. The first article by A. P. Singh and Vinod Kumar Gupta explored the role of stress that arises from life events and work culture in presence of depressive symptoms among executives in private sector organizations. They have reported that job negative (dimension of negative life events stress), work culture malleability, and obligation towards other (dimensions of work culture) emerge as significant predictors to influence the presence of depressive symptoms among executives. The next article by Ved Prakash Rawat and Dhananjay Kumar was conducted with the objective to assess the level of understanding and knowledge of general medical problems, physical health and reproductive health problems among literate and illiterate women of lower socioeconomic status. The findings indicated that both literate and illiterate women suffer from physical and reproductive health problems because of inadequate health literacy. Arvind K Birdie and Madhu Jain in their paper explore the personality (Introversion-Extroversion) as a predictor of coping strategy of parents with two children of different gender combinations. The next article aims to compare the mental health of adolescents abused during childhood from the adolescents with no such histories. The study also highlights the importance of considering underneath past traumas of childhood abuse, in addition to the current symptoms in adolescent psychopathology. A study was conducted by Huma Kamal and B. Hasan to examine the main and interactional effects of level of retardation, sleep disturbances and circadian rhythmicity upon behaviour problems of mentally retarded children. Rupan Dhillon and Saima Hafiz studied the relationship between coping style and psychological distress in a sample of 200 Kashmiri migrants. Authors found that migrants who lack adequate coping strategies to deal with the various stressors of migration suffer from more psychological distress. The next article enlisted examined suicidal ideation among the adolescent students of government, corporate and tribal high schools. Eulalia Almeida and Shivakumara K. in the present research aimed is to study the impact of body image on self esteem among early, middle and late adolescents; and to examine how the

relationship between body image and self-esteem may vary as a function of age. The next article by Bharati Roy investigated the incidence and pattern of problem behavior in school students and also examined the variation in problem behavior as related to gender and socio-economic status. Shyodan Singh and D. Chandra examined the role of social support, purpose in life, attitude toward death and leisure activities as key elements of psycho-social dynamics in determining health in elderly. Pooja, Deepti Hooda and NovRattan Sharma compare Subjective wellbeing across three generation. Authors reported that all the components of Subjective wellbeing were found to vary from family to family, whereas Generation differences were observed on Positive affect and Negative affect and not on Satisfaction with life. Anoop Kumar K V and T. Sasidharan have conducted a explorative case study to understand the dynamics of midlife crises in the Indian context. S. Punithavathi and C. Balakrishnamurthy attempts to study the pervasiveness of psychological empowerment of female college students in relation to their personality. The present issue also includes book review.

All the articles are scholarly and empirical.. Editors express gratitude to the contributors for their valuable inputs. We hope the articles will provide direction for young researchers. The members of the editorial board are of the view that sensitization of the readers towards health issues would go a long way in paving the path towards a more healthy society.

Editors

ROLE OF LIFE EVENTS STRESS AND WORK CULTURE IN THE PRESENCE OF DEPRESSIVE SYMPTOMS AMONG EXECUTIVES IN PRIVATE SECTOR ORGANIZATIONS

A. P. Singh* and Vinod Kumar Gupta**

ABSTRACT

The purpose of this paper is to explore the role of stress that arises from life events and work culture in presence of depressive symptoms among executives in private sector organizations. Depressive symptom is a risk factor for disability, absenteeism, job loss and subsequent unemployment. The present study was conducted on 210 executives and results reveal that job negative (dimension of negative life events stress) is significantly positively correlated with presence of depressive symptoms while work malleability and participation (dimensions of work culture) are significantly negatively correlated with presence of depressive symptoms. The results of stepwise multiple regression analysis show that job negative (dimension of negative life events stress), work culture malleability, and obligation towards other (dimensions of work culture) emerge as significant predictors to influence the presence of depressive symptoms among executives. The finding of this study will help in reducing the depression among executives so that organizations will run smoothly.

Keywords: Life events stress, Work culture, and Depressive symptoms.

Depression is most deliberating worldwide problem and poses a substantial public health challenge, both at the social and economic levels as well as the clinical level. Depression is a term that is applied to constellation of behaviour among whose most characteristic elements are motor and verbal retardation, crying, sadness, and loss of pleasant responses, loss of interest, self-devaluation, sleeplessness and anorexia (Beck, 1967). In the organization depression affects employee's productivity and performance. Depression is diagnosed through ICD

* Professor, Department of Psychology, Faculty of Social Sciences, B.H.U., Varanasi-221005. Email: apsbhu@gmail.com

** ICMR Junior Research Fellow, Department of Psychology, Faculty of Social Sciences, B.H.U., Varanasi-221005. Email: vkgupta.psychology89@gmail.com

and DSM but in the era of positive psychology focus has now been given on promoting the positive aspects and taking the action before case reach to its worst conditions. Therefore it would be much better to take action as soon as symptoms related depression begin to take place among normal employees because when these symptoms are not managed properly at the proper time and persist for long time then these may lead to different types of depression.

Depressive symptoms are defined as those that do not guarantee a psychiatric diagnosis of depression, occur even more often. Depressive symptoms by themselves constitute an important mental health problem, as they are associated with increased use of health services, disability, and risk of attempted suicide (Johnson, Weissman, & Klerman, 1992). If they exist for a long time then it is necessary to take the help of ICD and DSM to diagnose the different types of depression but before reaching this condition, the presence of depressive symptoms can be measured through well standardized psychological scales and this may help in managing the problems of depression at early stage.

In addition to this, it is also necessary to know the factors that may play important role in provoking the presence of depressive symptoms so that organizations will be able to reduce the depression among employees and to improve the employee's productivity and performance using proper intervention considering those predicting factors. Most likely, depressive symptoms are caused by a combination of genetic, biological, environmental, and psychological factors. Stressors and workplace conditions also contribute to depressive symptoms. Life events stress and work culture are important variables which may play important role in presence of depressive symptoms.

Life events stress is a combination of the major life events the individual experiences (Dohrenwend & Dohrenwend, 1985) and the meaning attributed to the events by the individual (Lazarus & Folkman, 1984). Life events stress is a umbrella term which include the stress related to all aspects of life. Thus life events stressors interact between life outside and life inside the organization and it might put pressure on employees. Employees having life events stress related to the outside of organization when come at the workplace, it also affects the work related activities at the workplace. Stress at home is carried into the work place, and vice versa. Life events stress is both positive and negative. According to Bhagat, McQuaid, Lindholm, & Segovis, (1985) positive stress may be defined as resulting from life event changes that produce a state of challenge coupled with disruptive pleasure for the individual. It is a dynamic condition in which an individual is confronted with an opportunity for being (or having or doing) what he or she desires. Negative stress on the other hand, is defined as resulting from life event changes that produce excessive and undesirable constraints and/or demand on the individuals.

Work culture is a pattern of shared basic assumptions – invented, discovered, or developed by a given group as it learns to cope with its problems of external

adaptation and internal integration – that has well enough to be considered valid and, therefore, to be taught to new members, as the correct way to perceive, think and feel in relation to those problems (Schein, 1985).

Life Events Stress and Depressive Symptoms

Life event stress and biological susceptibility have long been suspected to play important roles in the presence of a depressive episode (Jackson, 1986; Mazure, 1998; Monroe & Depue, 1991). Kendler, Thornton, and Gardner (2000) and Nelson et al., (2002) have confirmed the role of early life stress in the development of major depression, beyond genetic factors in twin studies. Exposure to chronic stressors (such as relationship and family problems, financial stress, and job strain) in addition to negative life events has also been linked with psychological distress or disorder, including depression (Bush 1999; Cui & Vaillant 1996; McGonagle, Katherine, Kessler, & Ronald, 1990; Pearlin 1989; Turner, Wheaton, & Lloyd 1995). Results from a hierarchical multiple regression demonstrated that negative life events were significant predictors of depressive symptoms (Dixon & Reid, 2000). Stressful life events have a substantial causal association with depression, and there is now compelling evidence that even early life stress constitutes a major risk factor for the subsequent development of depression (Charney & Manji, 2004). Dyson and Renk, (2006) in their study found that higher levels of stress were related to higher levels of depressive symptoms.

Work Culture and Depressive Symptoms

There has been considerable interest recently in the relationship between depression and the workplace. This interest is driven by the growing recognition that depressive disorders are highly prevalent in the workplace and have an enormous negative impact on performance, productivity, absenteeism, and disability costs. There is very few studies regarding work culture but a lot of studies is in terms of organizational culture. It has been suggested that organizational culture affects such outcomes as productivity, performance, commitment, self-confidence, and ethical behaviour (Buchanan & Huczynski, 2004; Shani & Lau, 2005; Ojo, 2009). The complete knowledge and awareness of organizational culture should help to improve the ability to examine the behavior of organization which assists to manage and lead (Brooks, 2006). Culture of organization has been associated with either positive or negative outcomes for either the organization or for individual employees. Positive outcomes for the individual include motivation and satisfaction, while negative outcomes include job insecurity and stress (Balthazard, Cooke, & Potter, 2006). In a study conducted by Chu et al, (2000), it has been found that in the workplace, the organizational culture and structure affects the employees and their health.

On the basis of above literature review regarding the relationship of life events stress and work culture with the presence of depressive symptoms it has been

clear that there is a few studies in which life events stress and work culture have been taken as predictors for presence of depressive symptoms among executives of Indian setting. So this study is an attempt to fill this gap.

Objectives

The aim of this study is to know the role of life events stress and work culture in depression among executives in private sector organizations.

1. To study the role of life events stress (positive and negative) in presence of depressive symptoms among executives in private sector organization.
2. To study the role of work culture in presence of depressive symptoms among executives in private sector organization.

Hypotheses

From the literature and empirical studies concerning the relationship among life events stress, work culture, and depressive symptoms following hypotheses are proposed:

1. Positive life events stress would be negatively correlated with presence of depressive symptoms as well as would predict presence of depressive symptoms among executives.
2. Negative life events stress would be positively correlated with presence of depressive symptoms as well as would predict presence of depressive symptoms among executives.
3. Different dimensions of work culture would be negatively correlated with presence of depressive symptoms as well as would predict presence of depressive symptoms among executives.

METHOD

Sample

Present investigation was conducted on 210 first level executives of different private sectors organizations in India. For this study participants were selected through convenience sampling from Varanasi, Mumbai, Lucknow, Delhi and Gurgaon through making direct contact that were easily and accidentally available and data was collected personally.

Tools

The following psychometric tools were used to assess the life events stress, work culture and presence of depressive symptoms in executives of Private Sector Organizations:

1. **Life Changes Experience Survey (Dohrenwend, Krasnoff, Askenasy, & Dohrenwend, 1978):** This scale consists of 35 items. Internal consistency reliabilities (Cronbach's Alpha) of the different sub scale was found to be 0.53 for job negative stress, 0.70 for

negative personal life stress, 0.58 for job positive stress, and 0.73 for positive personal life stress. High score on this scale shows high level of life events stress.

2. **Work Culture Scale (Mathur, Kanungo, & Aycan, 1996):** This questionnaire consists of 22 items. Six point response categories (6=strongly agree to 1=strongly disagree) were used in this scale. This questionnaire comprises five sub-scales namely malleability, proactive, obligation towards others, responsibility seeking, and participation. Internal consistency reliabilities (Cronbach's Alpha) of the different sub scales were found to be 0.71 for malleability dimension, 0.66 for proactive dimension, 0.68 for obligation towards others dimension, 0.69 for responsibility seeking, 0.68 for participation dimension.
3. **Epidemiological Studies Depression scale (CES-D) (Radloff, 1977):** In this scale, items are rated on the basis of ways how often they might have felt or behaved during the past week. This is a short, self-reporting scale intended for the general population. This inventory consists of 20 items. These items were selected from a pool of items from previously validated depression scales (e.g., Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Gardner, 1968; Raskin, Schulterbrandt, Reatig, & McKeon, 1969; Zung, 1965). This scale is used to measure depressive symptoms in the past week in non-clinical populations. The respondent is asked to respond to each item according to a 4-point Likert scale, with higher values corresponding to higher frequency of the item in the past week. Scores range from 0 to 60. High score on this scale shows high level of depression. In this scale higher scores (both item and total scores) indicate more depressive symptoms. A score of 16 or higher has been used extensively as the cut-off point for high depressive symptoms on this scale (Radloff, 1977). However, there is evidence that the CES-D, while a useful measure of the level of depressive symptoms, may not be a good tool for diagnosing clinical depression or major depression (Roberts, Vernon, & Rhoades, 1989). It is used primarily as a screening tool for depression, not as a diagnostic tool. The CES-D has been shown to be a reliable measure for assessing the number, types, and duration of depressive symptoms across racial, gender, and age categories (Knight, Williams, McGee & Olaman, 1997; Radloff, 1977; Roberts, Vernon, & Rhoades, 1989). High internal consistency has been reported with Cronbach's alpha coefficients ranging from .85 to .90 across studies (Radloff, 1977). In the present study, the internal consistency of the CES-DC was strong, with Cronbach's alpha of .87. Concurrent validity by clinical and self-report criteria, as well as substantial evidence of construct validity have been demonstrated (Radloff, 1977).

Procedure

First of all the necessary permission for data collection was sought from personnel or HR Department and appropriate authority from different organizations which were selected for the present study. Participants were contacted personally. After establishing rapport with the participants they were asked to read carefully the instructions given in the questionnaires. They are requested to respond on above mentioned measures. Scoring for all the above mentioned questionnaires were done accordingly as instructed in their manuals.

RESULTS AND DISCUSSION

To examine the hypotheses of this study data were analyzed in terms of correlation and stepwise regression analysis through SPSS 16.0 at the department of Psychology, Banaras Hindu University (BHU), Varanasi (U.P.). In the present study the life events stress and work culture have been treated as main predictors and presence of depressive symptoms as criterion variable.

**Table -1 Correlation coefficient of life events stress
(positive and negative) and dimensions of
work culture with depression**

Variable	Life events stress				Work culture				
	Positive life events stress		Negative life events stress						
	Job Positive	Person Positive	Job Negative	Person Negative	Work malleability	Proactive	Obligation towards others	Responsibility seeking	Participation
Depression	0.001	-0.037	0.173*	0.112	-0.235**	-0.030	-0.113	-0.011	-0.145*

* $p < 0.05$, ** $p < 0.01$

The results of the correlation analysis indicate that job negative (dimension of negative life events stress), was found significantly positively correlated with depression ($r = .173$, $p < .05$). The results of the correlation analysis also indicate that work malleability and participation (dimensions of work culture) were found significantly negatively correlated with depression ($r = -.233$, $p < .01$ & $r = -.145$, $p < .05$ respectively). Other dimensions of life events stress and work culture were not found significantly correlated with depression.

The results of the stepwise multiple regression analysis indicate that only work culture malleability (dimension of work culture), job negative (dimension of negative life-events stress), and obligation towards other (dimension of work

culture) were found significant predictors of presence of depressive symptoms in executives. Work culture malleability explains 5.1% of the total variance in predicting depression ($F=12.145, p<.001$) and job negative explains 3.6% of the total variance in predicting depression ($F=10.984, p<.000$) while obligation towards other explains 1.4 % of total variance in predicting depression ($F=8.814, p<.000$).

Table -2 Stepwise multiple regression analysis for depression (criterion variable), positive and negative life events stress & different dimensions of work culture (predictor variables)

Model	Predictor variable	R	R ²	Adjusted R	R ² Change	β	F
1	Work culture malleability	.235	.055	.051	.055	-.235**	12.145**
2	Job negative	.310	.096	.087	.041	.203*	10.984**
3	Obligation towards other	.337	.114	.101	.018	-.134*	8.814**

* $p<0.05$, ** $p<0.01$

The objective of the present study was to find out the role of life events stress and work culture in presence of depressive symptoms among executives in private sector organization. Obtained results did not confirm the first hypothesis of the present study that positive life events stress would be negatively correlated with presence of depressive symptoms and predict the presence of depressive symptoms. It is also noticeable that negative but insignificant direction of relationship with presence of depressive symptom was only for person positive but not for job positive. In studies it has been found that positive stress is a dynamic condition in which an individual is confronted with an opportunity for being (or having or doing) what he or she desires (Bhagat et al 1985) and this reduces the depression, anxiety, and tension whereas undesirable life event changes do not (Vinokur & Selzer, 1975).

In this study results are not like this. There may be many reasons behind this. Stress related to life events required a greater degree of personal adjustment. It may be that positive stress related to job and personal events require greater the degree of personal adjustment and it may be that participants were unable to make adjustment and became the victim of the normal symptoms of depression. This may be one explanation of this finding of the relationship between job positive and depression as Rahe (1972) has shown that the higher the risk of illness and greater the likelihood of major rather than minor illness. There may be also many reasons for the negative but insignificant relationship between person positive and depression. It may be other variable are moderating or mediating this relationship. There are individual differences in stress reactions. Mediators of the stress and illness connection, which probably include social resources, personality is

responsible for what Seley (1956) calls the distinctive way in each individual "takes to stressful life occurrence".

Obtained results partially confirmed the second hypothesis of this study that negative life event would be positively correlated with depression and would predict depression. A number of studies supported this finding. For example, Brown and Harris, (1978); Dohrenwend and Dohrenwend, (1974); Myers, Jerome, Jacob Lindenthal, & Max, (1972); Kraaij, Arensman, and Spinhoven, (2002).

The one reason of this relation may be that negative stressful life events affect the emotions and cognitions as well as coping strategies of individuals and finally it may lead individual to the depression. For example, regarding this explanation, Robinson (2000) studied how daily life events influence the affective and cognitive components of well-being. Results from cross-sectional and longitudinal studies of undergraduates showed that life events are closely related to mood states and mood states are closely related to cognitive wellness. According to the cognitive vulnerability model of depression (Beck, 1987), cognitive structures that generate negative content and consequently the processing of negative information constitute an enduring vulnerability for the development of depression. When confronted with negative life events, cognitive vulnerable persons may become depressed.

The results also partially confirmed the last hypothesis that work culture would negatively influence the presence of depressive symptoms among executives. A number of studies also support this result. For example, the studies conducted by Karasek (1979), Wang, and Patten (2001); Michie, and Williams (2003). It is so because culture of organization, through its norms, serves as a control mechanism to channel behaviors toward desired behaviors' and away from undesired behaviors. (Bulach, Lunenburg, & Potter, 2012; Hellriegel & Slocum, 2011). A good work culture in the organization leads to the reduction of depression in employees through enhancing motivation, employee participation, organizational commitment, positive job attitude, job satisfaction and reducing job stress, absenteeism in employees.

From this result it is clear that negative life events stress may play an important role in presence of depressive symptoms in executives as compared to positive life events stress and good work culture is essential for improving the performance and reducing the presence of depressive symptoms in executives.

Implication

This study may contribute in enhancing the production, effectiveness of organizations as well as mental health of executives through managing and reducing depression at the presence depressive symptoms among executives.

Limitation and Suggestion for Future Research

The data were obtained by self-report measures, and no diagnostic interview was conducted to corroborate the depression symptoms. A clinical interview is

desirable for an accurate assessment of the severity of depression. Future research should include other variables as a moderator or mediator to know the reason for this insignificant relationship of positive life events and depression as well as determining the applicability of these results to different levels in the organization. There is also a need of study to compare the level of depressive symptoms among different levels of executives.

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It is important that every woman has access to knowledge related to the spectrum of women's health issues, not only about her physical health system and reproductive system, but about all aspects of her body.

There is credible information available to women not only on physical problem (headache, pain in body, pain in abdomen, fever, weakness, loss of appetite etc), reproductive problems, eating disorders, stress, alcoholism, addictions, and depression, but also on basic topics such as good nutrition, health, and exercise.

There are major differences in body anatomy between males and females that require consideration. Anatomic differences between men and women go well beyond the reproductive and skeletal systems. If a woman is to make informed choices about her health care, she must understand her reproductive system. Many diseases affect both women and men alike but some diseases occur in women at a higher frequency. For example, gallstones are three to four times more common in women than in men.

Urinary tract infections, including cystitis (bladder infection) and kidney infection (pyelonephritis) are significant health problems that especially affect women. Kidney disease is a leading cause of high blood pressure (hypertension) and after the age of 50, hypertension is more common in women than in men.

Objectives:-The aim of the present study was to assess the level of understanding and knowledge of general medical problems and reproductive health problems among literate and illiterate women of lower socioeconomic status. The main objectives of the present study were as follows:

- 1- To assess health literacy among the rural women.
- 2- To assess the physical and reproductive health problems in rural women.

METHOD

Sample

The sample consisted of 60 women (married) aged between 20-40 years. They all were selected from the various villages of Gorakhpur District. Among the 60 participants 33 were illiterate, 7 had studied only upto 5th standard and 20 had studied from 8th standard to 12th standard. All of them had come to the health care center for treatment of their diseases.

Tools

A semi structured interview schedule was prepared to assess the awareness or knowledge of the respondents about their health and illness or disease. In this schedule the participants had to report about their physical health state and perception about their disease. There were total 14 open ended questions in the schedule. These were as follows:

1. What are your problems?
2. What do you know about your disease?
3. Do you know about the causes of your disease?

4. Which person do you told first about your disease?
5. When you felt that you should consult a doctor?
6. Who take decisions to consult a doctor for you?
7. Are you take or have home medicine?
8. Do you know about common female disease?
9. What do you know about vitamins?
10. What do you know about anemia?
11. Do you understand after reading hospital instructions?
12. Who tell you about that how to take prescribed medicine by doctor?
13. Do you understand the instructions of doctor?
14. Do you understand health related suggestions presented by televisions and radios?

Procedure: Each subject was contacted individually and rapport was established. All the subjects were informed about the purpose of the study and their consent was taken. The respondent was informed that there were no wrong or right answer of these questions, and they could give their response or opinion without any hesitation. After that, the investigator conducted an open ended interview using the 14 open ended questions and the views and opinions were recorded. In some of the cases the respondents were unable to understand English or Hindi language, in such cases mixed Hindi with Bhojpuri dialect language was used to communication with them.

RESULTS AND DISCUSSION

First of all the major themes were sorted out and their frequencies was calculated for both groups. On the basis of frequency, percentage was calculated and the data were also analyzed with the help of qualitative analysis.

Table-1: Percentage of Health related problems reported by literate and illiterate women

S.N.	Problems	Literate	Illiterate
1.	Pain in Abdomen, Fever, Weakness, Loss of appetite	15%	21%
2.	Backache Leucorrhea	18%	14%
3.	Continuous fever, Yellow Urine, heat in Body and chillness	10%	13%
4.	Long lasting menstruation after tubectomy, profuse bleeding, backache	6%	10%
5.	Flatulency	8%	7%
6.	Apathy	9%	11%
7.	Piles, Fever	16%	9%
8.	Otorrhea, earache, itching in the ear	4%	4%
9.	Dysmenorrhea	8%	6%
10.	Dysnea	6%	5%

Table 1 indicates the various health related problems of the literate and illiterate villager women. The first question was about the problem for which they have come to the hospital. Fifteen percent literate and 21% illiterate women reported pain in abdomen region, fever, weakness and loss of appetite. Backache and leucorrhea reported by 18% literate and 14% illiterate women while 10% literate and 13% illiterate women reported continuous fever, yellow urine, heat in body and chillness. Six percent literate and 10% illiterate women reported prolonged menstruation after tubectomy, profuse bleeding and backache. Eight percent literate and 7% illiterate women reported flatulency. Further, 9% literate and 11% illiterate women reported apathy over a long time. Sixteen percent literate and 9% illiterate women reported piles with fever. Further, 4% literate and 4% illiterate women reported otorrhea, earache, and itching in the ear. Eight percent literate and 6% illiterate women reported dysmenorrhea and 6% literate and 5% illiterate women reported dysnea.

With regard to knowledge about the disease and the causes of the disease, it was found that 90% literate and 100% illiterate women reported that they did not know about their disease and only 10% literate women were aware of their disease. However, 40% literate and 11% illiterate women reported that they know about the causes of their disease while 60% literate and 89% illiterate women did not know about the causes of their disease.

Table-2: Preferences of Literate and Illiterate women to confide about their disease

S.N.	Preference of women	Literate	Illiterate
1.	Husband	15%	13%
2.	Father	6%	2%
3.	Mother	30%	44%
4.	Parents	10%	14%
5.	Sister	6%	11%
6.	Close friend	12%	9%
7.	Brother	3%	0%
8.	Nurse	8%	3%
9.	Doctor	10%	4%

Table-2 shows the preferences of literate and illiterate women to confide about their study. Fifteen percentage literate and 13% illiterate women firstly reported to their husband about their illness, 6% literate and 2% illiterate women firstly reported to their father about their illness, 30% literate and 44% illiterate women firstly reported to their mother about their illness, 10% literate and 14% illiterate women firstly reported to their parents about their illness, 6% literate and 11% illiterate women firstly reported to their sister about their illness, 12% literate and 9% illiterate women firstly reported to their close friend about their

illness, 3% literate and 0% illiterate women firstly reported to their brother about their illness, 8% literate and 3% illiterate women firstly reported to the nurse of the hospital about their illness. And out of these women only 10% literate and 4% illiterate women firstly reported to the doctor of hospital about their illness.

With regard to consultation of a doctor, all the respondents reported that they had consulted a doctor.

However, the decision of consulting a doctor was taken by the husband in 45% cases for the literate women and 37% cases for the illiterate. For 30% cases of literate women and 58% cases for the illiterate women their parents took the decision, while only 25% literate women and 5% cases illiterate women took the decisions herself.

With regard to usage of home remedies, only 12% literate women and 45% illiterate women reported the usage of home remedies for their health related problems.

Further probing about the knowledge of common female diseases in literate and illiterate women, it was found that 67% literate women and 13% illiterate women had no knowledge about common female diseases.

Further, it was found that only 57% literate and 18% illiterate women reported that they knew about the importance of dietary and supplementation of vitamins. However, the respondents were not aware of nutritional deficiency related diseases as knowledge of anemia was found only in 12% literate and 2% illiterate women.

Another major problem which was evinced was that only 44% literate could understand the instructions given in the hospital while none of the illiterate women showed any comprehension. Only 56% literate women and 12% illiterate women understand the instructions of doctor. Also, 72% literate and 85% illiterate women reported that their husband told them how to take the prescribed medicine while the brother provided this information to 8% of literate and 15% of illiterate and only 20% of the literate women could do so by themselves.

With regard to impact of audio-visual media related awareness campaigns, 84% literate and 58% illiterate women reported that they understood the health related suggestions presented on televisions and radios.

Considered together, the results indicate that the level of health literacy is very low in illiterate women in comparisons to literate women of rural area but the differences marginal. Both the literate and illiterate rural women reported various physical and reproductive health problems but they were not aware of the nature of severity of the problem. Nor were they aware of the antecedents of these problems and in many of the cases they ignored or denied the possibility of occurrence of the disease. The major deterrent to coping with their health related problems was that they could not understand the instructions given by the hospitals staff and as suggested by their doctor. This had a major impact on adherence to

the prescribed medical regime. They were dependent on their caretakers for following the doctor's instructions and taking the medicines as prescribed by the doctor. They were also not to assimilate the health related information which was being provided by televisions, radios or other mass media.

In many cases the decision to consult a doctor was also not taken by them as in approximately 90% cases all the decisions regarding their health related problems such as physical and reproductive health problems were taken by their parents, husbands or others.

The present results assume importance in light of fact that women's health in India can be compromised by multiple variables which vary across geographical, socioeconomic and culture dimension (Chatterjee & Paily, 2011). Tarozzi (2000) reported that nearly 70 percent of non-pregnant women and 75 percent of pregnant women were anemic. One of the main contributors to their malnutrition is the gender specific selection of the distribution of food resources.

To adequately improve the health of women in India, multiple dimensions of wellbeing must be analyzed in relation to global health averages and also in comparison to men in India. Health is an important factor that contributes to human wellbeing and economic growth.

Addressing the gender disparities that exist in healthcare and improving the health outcomes can contribute to economic gain through the creation of quality human capital and increased levels of savings and investment. Rao and Rao (2013) have reported that women are negatively affected by the geographic bias within implementation of the current healthcare system in India. Of all health workers in the country, nearly two thirds are men. This especially affects rural areas where it has been found that out of all doctors, only 6 percent are women. This translates into approximately 0.5 female allopathic physicians per 10,000 individuals in rural areas. Paul and Krupp (2012) have also reported a disparity in access to maternal care between rural and urban populations is one of the ramifications of a highly concentrated urban medical system. According to Government of India National Family Health Survey (NFHS II, 1998-1999) the maternal mortality in rural areas is approximately 132 percent the number of maternal mortality in urban areas.

In 2005 India enacted the National Rural Health Mission (NHRM). Some of its primary goals were to reduce infant mortality and also the maternal mortality ratio. Additionally, the NHRM aimed to create universal access to public health services and also balance the gender ratio. Harish and Panda (2011) have reported that although India was able to improve some measures of maternal health since the enactment of the NHRM in 2005, the country was still far behind most emerging economies.

Low health literacy negatively affects a woman's health knowledge, preventive behavior, ability to navigate the health care system, and ability to care for her children. Interventions to increase a woman's health literacy include written education materials with proper reading level and design, clear communication, and education to increase health knowledge, self-efficacy, and self-advocacy skills. Health literacy should also be incorporated in nursing education programs.

Finally it can be suggested that there will be hazards consequences of the low health literacy. Effective approaches can be employed to attenuate the adverse effect on women's health. Health care providers should increase the initiatives for awareness campaigns within the health care system to improve health literacy.

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PERSONALITY AS A PREDICTOR OF COPING STRATEGY IN PARENTS HAVING TWO CHILDREN OF DIFFERENT GENDER COMBINATION

Arvind K Birdie* and Madhu Jain*

ABSTRACT

The present study aims to explore the personality (Introversion-Extroversion) as a predictor of coping strategy of parents with two children of different gender combinations. For the purpose of study, a random sample of 75 couples was taken out of which 25 parents were selected with only two boys, 25 parents were taken with only two girls and 25 percent parents were selected with one boy and a girl. Data was collected by using Kundu's (1976) Personality test of Introversion-Extroversion and Folkman and Lazarus' Coping Strategies Scale. Statistical techniques like mean, standard deviation and analysis of variance were employed to draw inferences. Results revealed that there was significant difference between the parents having children of different gender combinations regarding all dimensions of coping strategies. Results also revealed that personality doesn't play any significant role in determining coping strategies.

Keywords: Personality, Introversion-Extroversion, Coping Strategies, Parents Children

The group that most affects the human personality is the family (Blau & Scott, 1970). Family is a miniature society. In Indian family male offspring was desired with an attitude of protecting family name and protection. He is also considered to be an economic asset and might eventually become the family's main economic support. In contrast female child is still considered to be a problem for the family, although mentally and emotionally they become asset for the

* Acting Principal & Associate Professor, IIMT School of Management (Now Vedatya), Gurgaon, arvindgagan@gmail.com Corresponding author.

** Associate Professor, Department of Psychology, University of Rajasthan, Jaipur

mothers and their families due to their strong attachment and intimate relationship with their families. In Indian culture the family is a self creating and self liquidating organization. Normally it consists of three sub system which in their development is interlocking and compensatory- the spouse system, parent-child system and the sibling system.

Catell (1956) equates personality with the individual aspects of behavior and directs his attention to the behavior of individual and maintains that it should have predictive power. As personality has its own unique style of adjustment with the environment, it affects ones coping mechanism and style.

Coping refers to efforts to master conditions that task or exceeds adaptive resources (Monat & Lazarus, 1977). Lazarus and Folkman (1984) defined coping as a person's constantly changing cognitive behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person's resources. Coping can have an effect on three kinds of outcomes psychological, social and physiological.

Seiffge-Krenke, Igne & Schulman (1990) found the significant main effect for age gender in coping behavior in which Germans were more influenced by situational demand with pronounced approach avoidance behaviors. Israelis showed less variability in coping behaviors across situations laid greater stress on cognitive factors.

Parkes (1990) tested the hypothesis that direct coping would moderate relations between work, stress and mental health outcome, whereas suppression (a form of emotion focused coping) would show an overall effect on outcome. Result revealed that direct coping would moderate relations between work, stress and mental health outcome, whereas suppression (a form of emotion focused coping) would show an overall effect on outcome. Result revealed that men reported less of suppression than did women.

As individuals have their own personalities and even in families we have our individual differences and accordingly families also affect individuals, keeping in mind the above variables in Indian society where male offspring and female child has its own effect on dynamics of family, it was decided to explore the introversion-extraversion as a predictor of coping strategy of parents with two children of different gender combinations.

METHOD

Sample: The sample consisted of total 75 couples of the age range from 30-45 years of middle class. Out of 75 couples 25 parents were selected who have only two daughters. 25 parents were taken who have only two sons and

25 parents were selected who have one daughter and a son, as shown in table 1

Table 1: Sample details

<i>Groups</i>	<i>Parents</i>	<i>Children</i>
Parents with two girls	25	25 males and 25 females
Parents with two boys	25	25 males and 25 males
Parents with one girl and a boy	25	25 males and 25 females
Total	75	150

Measures

1. *Personality test- Introversion-Extroversion by Kundu (1976)*. The inventory consists of 70 items with uneven number of response choices divided into 5 blocks. Block reliabilities as well as total test reliability have been determined by split- half method applying Spearman Brown formula. The Cronbach's alpha of the whole test is 0.73. Scale is validated against Introversion-Extraversion score of Eysenck Personality Inventory.
2. *Coping Strategies Scale by Folkman and Lazarus (1985)*. It is a 4-point scale. Scores for each dimensions on coping styles ranges from 0 to 3. The minimum scores on each scale is 0 and maximum depends on the number of items in each scale. The scale has 8 dimensions as confronting coping, Distancing, Self Control, Seeking social support, Accepting Responsibility and Escape avoidance, planful problem solving and positive reappraisal.

Procedure

With the help of friends and relatives, researcher came to know about the couples that suits the sample. Then researcher interacted and paid personal visit to their houses. After developing initial rapport, a specified time and duration for filling questionnaires was fixed. Before administering the questionnaires, they were assured of the confidentiality of their responses. Special care was taken in administering the test properly, minimizing the effect of fatigue by administering the test in three sessions.

Statistical analysis

Mean and standard deviation were computed for all the variables and ANOVA was employed to find out the independent and interactive effect of different variable.

RESULTS AND DISCUSSION

Table 2.1 shows the mean of girl's parents is higher than the other two parents. In Table 2.2 coping strategy's confronting coping of parents are analyzed. It is explained by the fact that usually frustration leads to aggression. The parents who are having both a girl and a boy are better adjusted as they are less frustrated.

The mean score of boys' parents is 13.48 and means of girls' parents is 12.50 whereas parents who have both boy and girl scored mean of 15.66 which is the highest among all. This shows that the girls' parents are trying to be attached from the society. They are more socially concerned as they have their daughters to support and cooperate in the society. The variation between the personality i.e. between extroversion and introversion is also found to be significant at .001 levels. This shows there is difference between extrovert personality and introvert personality. Diener, Larsen and Emmons, 1984; Emmons and Diener, 1986 assumed that social situations provide a good fit for extroverts personality according to this, extrovert should be more likely than introverts to choose social situations over non social situations and extroverts should be more likely than introverts to experience pleasant affect in social situation.

Table 2.1: Mean and SD of Coping Strategy's Confronting Coping

<i>Variables</i>	<i>Mean</i>	<i>SD</i>
For entire Population	14.14	1.9
Personality (Boys Parents)	14.10	1.5
Extrovert	13.89	1.5
Introvert	14.75	1.6
Personality (Girls Parents)	15.8	1.02
Extrovert	15.9	.965
Introvert	15.6	1.14
Personality (Boy & Girl Parents)	12.50	1.44
Extrovert	12.5	1.4
Introvert	12.5	1.4

Table 2.2: 3X2 ANOVA for Coping Strategy's Confronting Coping

<i>Source of Variation</i>	<i>Sum of Squares</i>	<i>df</i>	<i>Mean Square</i>	<i>F</i>	<i>Level of Significance</i>
Main Effects	276.408	3	92.13	48.99	.001
Between Parents (A1, A2, A3)	274.228	2	137.114	72.908	.001
Between Personality (B1, B2)	.728	1	.728	.387	N.S
2 Way Interaction (AXB)	6.83	2	3.41	1.818	N.S
Within Groups	270.814	144	1.88		
Total	554.060	149	3.719		

Table 2.3: Mean and SD of Coping Strategy's Distancing

<i>Variables</i>	<i>Mean</i>	<i>SD</i>
For entire Population	13.8	2.0
Personality (Boys Parents)	13.48	1.8
Extrovert	13.23	1.9

Introvert	14.25	1.5
Personality (Girls Parents)	12.5	1.54
Extrovert	12.5	1.59
Introvert	12.5	1.45
Personality (Boy & Girl Parents)	15.6	1.15
Extrovert	15.4	1.16
Introvert	16.06	1.0

Table 2.4: 3X2 ANOVA for Coping Strategy's Distancing

Source of Variation	Sum of Squares	df	Mean Square	F	Level of Significance
Main Effects	269.8	3	89.9	37.5	.001
Between Parents (A1, A2, A3)	256.5	2	128.267	53.53	.001
Between Personality (B1,B2)	8.174	1	8.17	3.4	.001
2 Way Interaction (AXB)	5.00	2	2.500	1.043	N.S
Within Groups	345.02	144	2.39		
Total	619.84	149	4.160		

Table 2.5: Mean and SD of Coping Strategy's Self Control

Variables	Mean	SD
For entire Population	17.14	2.0
Personality (Boys Parents)	17.30	1.9
Extrovert	17.31	2.00
Introvert	17.25	1.9
Personality (Girls Parents)	15.56	1.78
Extrovert	15.52	1.74
Introvert	15.64	1.94
Personality (Boy & Girl Parents)	18.56	1.07
Extrovert	18.47	1.10
Introvert	18.75	1.00

The table 2.6 shows that the main effects have been found to be highly significant. The two way interaction between the variables is insignificant. Table 2.6 shows independent variable does not affect the dependent variable but when independently observed, it is found that parents of all the groups differ significantly. The table 2.8 coping strategy's social support is analyzed. The main effects are found to be highly significant but the interaction effects are found to be insignificant. Table 2.7 shows mean for the entire population is 14.27. Mean score of the parents having boy children is 13.26, parents with girl children is 15.27 and parents who have the children of both sexes is 13.84. This means that parents who are having girl children are seeking for informational support and emotional support from friends or from family members as they scored highest in this factor.

Parents who are having only boys require less support from the family as they owned both males and parents who have both children of either sex also require social support as they owned a girl child. Parents require social support from family members and friends at the time of marrying them. They have concern about girl as she has to get married and go into other family and thus they require informational support. Designer & Cassisi (1996) suggested that women are more likely to cope by seeking social support and men are more likely to cope through hedonistic escapism.

Table 2.6: 3X2 ANOVA for Coping Strategy's Self Control

Source of Variation	Sum of Squares	df	Mean Square	F	Level of Significance
Main Effects	227.351	3	75.78	27.138	.001
Between Parents (A1, A2, A3)	226.112	2	113.056	40.486	.001
Between Personality (B1,B2)	.431	1	.431	.154	NS
2 Way Interaction (AXB)	.592	2	.296	.106	N.S
Within Groups	402.11	144	2.79		
Total	630.060	149	4.229		

Table 2.7: Mean and SD of Coping Strategy's Seeking Social Support

Variables	Mean	SD
For entire Population	14.27	1.97
Personality (Boys Parents)	13.26	2.2
Extrovert	13.05	2.1
Introvert	13.91	2.4
Personality (Girls Parents)	15.72	1.1
Extrovert	15.76	1.2
Introvert	15.62	.95
Personality (Boy & Girl Parents)	13.84	1.4
Extrovert	14.02	1.5
Introvert	13.35	1.1

Table 2.8: 3X2 ANOVA for coping strategy's Seeking Social Support

Source of Variation	Sum of Squares	df	Mean Square	F	Level of Significance
Main Effects	165.37	3	55.12	19.60	.001
Between Parents (A1, A2, A3)	164.70	2	82.35	29.29	.001
Between Personality (B1,B2)	.005	1	.005	.002	.001
2 Way Interaction (AXB)	11.54	2	5.77	2.054	N.S
Within Groups	404.86	144	2.81		
Total	581.79	149	3.905		

Table 2.9: Mean and SD of Coping Strategy's Accepting Responsibility

<i>Variables</i>	<i>Mean</i>	<i>SD</i>
For entire Population	9.1	1.33
Personality (Boys Parents)	9.2	1.4
Extrovert	9.21	1.4
Introvert	9.50	1.24
Personality (Girls Parents)	8.72	1.24
Extrovert	8.69	1.26
Introvert	8.78	1.25
Personality (Boy & Girl Parents)	9.38	1.27
Extrovert	9.50	1.28
Introvert	9.12	1.25

Table 2.10: 3X2 ANOVA for Coping Strategy's Accepting Responsibility

<i>Source of Variation</i>	<i>Sum of Squares</i>	<i>df</i>	<i>Mean Square</i>	<i>F</i>	<i>Level of Significance</i>
Main Effects	12.66	3	4.22	2.41	N.S.
Between Parents (A1, A2, A3)	12.65	2	6.329	3.62	.001
Between Personality (B1,B2)	.009	1	.009	.005	N.S.
2 Way Interaction (AXB)	2.369	2	1.18	.678	N.S.
Within Groups	251.56	144	1.74		
Total	266.59	149	1.78		

In table 2.10, the coping strategy's Accepting Responsibility is analyzed. Neither the main effects nor the interactions are significant. But the differences between the parents are found to be significant at .001 levels. Table 2.9 shows that parents having children of different gender a combination accepts their responsibility more confidently and with more zealousness.

Table 3.1: Mean and SD of Coping Strategy's Escape Avoidance

<i>Variables</i>	<i>Mean</i>	<i>SD</i>
For entire Population	18.87	1.9
Personality (Boys Parents)	19.40	1.7
Extrovert	19.34	1.8
Introvert	19.58	1.24
Personality (Girls Parents)	20.14	1.49
Extrovert	20.19	1.52
Introvert	20.00	1.46
Personality (Boy & Girl Parents)	17.08	1.30
Extrovert	17.08	1.28
Introvert	17.06	1.38

Table 3.2: 3X2 ANOVA for Coping Strategy's Escape Avoidance

Source of Variation	Sum of Squares	df	Mean Square	F	Level of Significance
Main Effects	236.89	3	78.964	33.56	.001
Between Parents (A1, A2, A3)	236.83	2	118.41	50.33	.001
Between Personality (B1,B2)	.008	1	.008	.006	N.S
2 Way Interaction (AXB)	2.91	2	1.45	.195	N.S
Within Groups	338.78	144	2.35		
Total	576.59	149	3.870		

Table 3.3: Mean and SD of Coping Strategy's Planful Problem Solving

Variables	Mean	SD
For entire Population	14.34	1.76
Personality (Boys Parents)	14.20	1.98
Extrovert	14.02	1.93
Introvert	14.75	2.13
Personality (Girls Parents)	13.74	1.60
Extrovert	13.55	1.53
Introvert	14.21	1.71
Personality (Boy & Girl Parents)	15.08	1.41
Extrovert	14.88	1.53
Introvert	15.50	1.03

Table 3.4: 3X2 ANOVA for Coping Strategy's Planful Problem Solving

Source of Variation	Sum of Squares	df	Mean Square	F	Level of Significance
Main Effects	59.60	3	19.868	7.082	.001
Between Parents (A1, A2, A3)	44.004	2	22.002	7.082	.001
Between Personality (B1,B2)	13.245	1	13.245	4.721	.001
2 Way Interaction (AXB)	.056	2	.028	.010	N.S
Within Groups	403.99	144	2.80		
Total	463.660	149	3.112		

Table 3.5: Mean and SD of Coping Strategy's Positive Reappraisal

Variables	Mean	SD
For entire Population	17.30	1.94
Personality (Boys Parents)	17.92	1.68
Extrovert	17.86	1.66
Introvert	18.08	1.83

Personality (Girls Parents)	15.84	1.79
Extrovert	15.52	1.82
Introvert	16.64	1.49
Personality (Boy & Girl Parents)	18.14	1.47
Extrovert	18.23	1.55
Introvert	17.93	1.28

Table 3.6: 3X2 ANOVA for Coping Strategy's Positive Reappraisal

Source of Variation	Sum of Squares	df	Mean Square	F	Level of Significance
Main Effects	164.37	3	54.79	20.205	.001
Between Parents (A1, A2, A3)	160.80	2	80.40	29.648	.001
Between Personality (B1,B2)	3.29	1	3.29	1.21	N.S
2 Way Interaction (AXB)	10.62	2	5.31	1.95	N.S
Within Groups	390.50	144	2.71		
Total	565.50	149	3.79		

Table 3.7: Mean and SD of Total Coping Strategy

Variables	Mean	SD
For entire Population	100.20	7.83
Personality (Boys Parents)	99.54	5.10
Extrovert	102.60	6.40
Introvert	98.50	4.18
Personality (Girls Parents)	92.70	4.81
Extrovert	93.33	4.77
Introvert	92.64	4.80
Personality (Boy & Girl Parents)	108.36	3.40
Extrovert	108.62	2.79
Introvert	108.23	3.47

Table 3.8: 3X2 ANOVA for Total Coping Strategy

Source of Variation	Sum of Squares	df	Mean Square	F	Level of Significance
Main Effects	6256.80	3	2085.60	106.38	.001
Between Parents (A1, A2, A3)	6091.97	2	3045.98	155.36	.001
Between Personality (B1,B2)	93.24	1	93.24	4.75	.001
2 Way Interaction (AXB)	64.036	2	32.08	1.63	N.S
Within Groups	2823.16	144	19.60		
Total	9144.00	149	61.36		

Table 3.2 shows personality does not effect escape avoidance coping strategy's of parents having children of different gender combinations. The mean and S.D in Table 3.1 reveal that parents with only girls scored highest with the mean score of 20.14. It shows that parents do not want to remain detach from the society. They want to be with them and maintain relations so that it enables them to seek help and information whenever required. Planful problem solving of parents in table 3.4 the variations between parents and personality is significant at .001 levels. But the combined effect of both, personality and parent is found to be insignificant. The mean comparisons shows that parents having children of both the sexes plan out the solutions for the problems more effectively and also adopt analytical approach in solving the problem. In table 3.5 of mean and S.D between parents having children of different gender combinations and personality with positive reappraisal is analyzed. The main effects (20.205) proved that there is a strong relationship between the variables. In the mean scores of coping strategy's positive reappraisal of parents all the three groups has a difference in their scores. Those parents who have the children of both sexes have a more positive outlook towards their life as compared to the parents having only girls.

From the table 3.8 the main effect is significant at .001 levels. The difference between the scores of parents and personality types were significant. Table 3.7 shows that the mean score of the parents having the children of either sex is 108.36 which is high as compared to the parents of other two groups. The reason may be as they have the children of both sexes, thus they can fulfill their desires and enjoying the privileged of having the children of having the children of either sex. Thus, they can easily cope up with the environment. In Indian society the gender stereotype roles are very much still present and for daughters, parents have their fears and tensions regarding marriage. According to Lazarus and Folkman (1984) the cognitive theory of psychological stress and coping is transactional theory, which states that the person and environment exist in a dynamic mutually reciprocal relation. Thus the hypothesis that coping strategies of the parents having children of different combinations is different is significantly proved.

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MENTAL HEALTH OF ABUSED AND NON-ABUSED ADOLESCENTS: A COMPARATIVE STUDY

Damanjit Sandhu and Shubhdip Kaur***

ABSTRACT

This investigation was an attempt to compare the mental health of adolescents abused during childhood from the adolescents with no such histories. The criteria for estimation of mental health of adolescents were: 'problem behaviour', 'perception of family environment', and 'problems in the interpersonal relations with parents, peers and teachers'. Around 1557 adolescent boys and girls between the age group of 15-18 years were screened for possible abuse during childhood. Two groups of adolescents (abused group and non-abused group), each comprising 100 adolescents were formed. All the adolescents were administered Youth Self Report (YSR), Family Environment Scale (FES), and Clinical Assessment of Interpersonal Relationships (CAIR). The results obtained from the comparison of scores on the measure of problem behaviour, family environment and interpersonal relations, of abused- and non-abused groups revealed significant support for all the hypotheses of this study. This indicated significant differences in the mental health of abused and non-abused adolescents. The study suggests that while considering the adolescent psychopathology, therefore, the prime or sole focus of concern should not be the current symptoms only, but the underneath past traumas of childhood abuse also.

Keywords: Adolescents, Childhood abuse, Mental health, Problem behaviour, Family environment, and Interpersonal relationships.

Good mental health is a vital resource for individuals, families, communities and nations. Mental health is "a state of well-being in which individuals realize his or her own abilities, can cope with the normal stresses of life, can work

* Assistant Professor, Department of Psychology, Punjabi University, Patiala - 147002, Punjab, India.

** Senior Research Fellow, Department of Psychology, Punjabi University, Patiala - 147002, Punjab, India. All correspondence regarding this paper should be addressed to the second author (i.e. Shubhdip Kaur) at shubh.phd@gmail.com

productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organization [WHO], 2004, p.10). Mental Health Foundation in 2009 postulated that mental health is much more than just the absence of mental health problems and disorders. It is about living a full and creative life and being able to deal with the ups and downs of life (as cited in Ramsay, 2009). In total, "Good mental health is about resilience, adapting to challenges and adversity, getting the most out of life and having a positive sense of well-being and self-worth" (North South Inter-Parliamentary Association [NSIPA], 2013, p. 4).

Further, WHO (2014) also posited an associated between poor mental health and human rights violation; and childhood abuse is one such human right violation (article 19, United Nations Convention on the Rights of the Child [UNCRC], 2011). WHO (1999) defines child abuse as "all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power" (p. 15) and has identified four categories of child abuse. These are - *Physical abuse* (results in actual or potential physical harm from an interaction or lack of an interaction, that is reasonably within the control of a parent); *Sexual abuse* (involving child in sexual activity that he or she does not comprehend, unable to give informed consent to, is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society); *Emotional abuse* (failure to provide a developmentally appropriate, supportive environment to child) and *Neglect* (failure to provide for the development of the child in all spheres) (WHO, 1999).

Significant problem behaviour, such as depression, emotional instability, and a tendency to get aggressive and violent with others, may be presented later in life by the children who have experienced abuse early in their lives (Stirling, Amaya-Jackson, & Amaya-Jackson, 2008). Childhood abuse is found to be associated with problem behaviours, such as anxiety disorders and depression, especially for adolescents (Gilbert et al., 2009). The age of the child is also a very significant factor as the earlier children are abused, the more likely they are to develop problem behaviours during adolescence (Frederico, Jackson, & Black, 2008).

Further, adolescents with childhood histories of abuse often perceive their family environment negatively. The family environment of children with abusive parents is often characterized by lack of expressiveness and harmful caregiver-child interactions (Glaser, 2011). Family conflict seems to function as an uncontrollable stressor which tends to increase psychological distress amongst the adolescent victims of childhood abuse. A conflictual family environment is likely to be associated with a general sense of uneasiness and discomfort because

of its unpredictability. In addition, it may exert its effects indirectly by changing the nature of parent-child relationship through loose or inconsistent disciplinary practices or by the overt expression of parental hostility towards the adolescent. Similarly, family cohesion seems to serve a buffering or protective function under stress, and therefore it may function to foster positive psychological adjustment. Family cohesion serves to reduce the impact of stressful events and further, high level of cohesion is accompanied by high level of positive reinforcement which mitigates the development of psychological problems among the victimized adolescents (Meyerson, Long, Miranda, & Marx, 2002).

The traumatized children often experienced what Pynoos (1994) has called – a fracture of the protective shield. These children have experienced a reduced confidence in their parents' ability to protect them from danger. Hence, they have suffered a change in core assumptions about the world and the people in it, that the world is not a safe place and the other people are not good at all (Janoff-Bulman, as cited in Dittmann & Jensen, 2014). Adolescents with abuse histories often exhibit social cognition biases in how they perceive their social worlds (Pollak & Sinha, 2002).

Lack of problem behaviours (National Research and Development Centre for Welfare and Health [NRDC], 2000) and adequacy in interpersonal relationships within and outside family (Vaillant, 2003) are amongst the important components of mental health. Hence an individual with deficits in mental health is likely to display problem behaviours, and problems in the domains which require interactions with people.

Objective

The objective of the present study was to investigate differences in mental health of adolescents abused during childhood and the adolescents with no such histories.

Hypotheses

1. Adolescents abused during childhood will display more behaviour problems as compared to non - abused adolescents.
2. Adolescents abused during childhood will report more family conflict, and lower family cohesion and expressiveness as compared to non - abused adolescents.
3. Adolescents abused during childhood will display more problems in interpersonal relations with parents, peers and teachers, as compared to non - abused adolescents.

METHOD

Sample

A sample of 1557 adolescents boys (N = 650) and girls (N = 907) between the age group of 15 – 18 years (S.D. = 0.53) from various schools of Punjab

(India), were screened for possible abuse during childhood. Among these, 100 adolescents, with confirmed histories of abuse, were included in the abused group and an equal number of adolescents with no histories of abuse formed the non-abused group of this study. All subjects were matched on age, middle socio-economic status and two-parent nuclear families.

Tools

Childhood Trauma Questionnaire (CTQ; by Bernstein & Fink, 1998): CTQ is a 28-item self-report inventory that provides screening for histories of different types of childhood abuse. CTQ is appropriate for adolescents aged 12 and over. Internal consistency reliability coefficients for the CTQ scales were computed with Cronbach's alpha for all of the validation samples (such as Adult Substance Abusers, Adolescent Psychiatric Inpatients, College Undergraduates, etc.). Reliability coefficients ranged from satisfactory to excellent, with the highest for the Sexual Abuse Scale (median = .92) and the lowest for the Physical Neglect Scale (median = .66). Further, for construct validity CTQ was validated with data from over 2,000 respondents, including both clinical and non-referred groups and satisfactory results were obtained (Bernstein & Fink, 1998).

Youth Self Report (YSR; by Achenbach & Rescorla, 2001): YSR is a 112 items inventory, which can be administered to individuals aged between 11-18 years old, to describe their own behavioural functioning. Achenbach and Rescorla (2001) reported the mean 8 days test-retest reliability to be .87 and cronbach's alpha computed for the demographically matched referred and nonreferred samples to be .95 for total problem scale of YSR. The content validity of YSR has been strongly supported by nearly four decades of research, consultation, feedback, and refinement, as well as the by the evidences for the ability of all item to discriminate significantly ($p < .01$) between demographically similar referred and nonreferred children. The construct validity of the scales has also been supported in many ways, such as evidence for significant associations with analogous scales of other instruments (such as Conners Scales, Behaviour Assessment System for Children Scales) and with DSM criteria; by cross-cultural replications of syndromes; by genetic and biochemical findings; and by predictions of long-term outcomes (Achenbach & Rescorla, 2001).

Family Environment Scale (FES; by Moos & Moos, 1994): For the present study, only Relationship Dimensions of FES was used. This dimension, through its 27 items, measures Cohesion, Expressiveness, and Conflict within any family. The internal consistency reliability (Cronbach alpha), corrected average item subscale correlations, 2-month Test-Retest Reliability and 4-month Subscale Stability for the Cohesion subscale ($N = 1,067$) came out to be .78, .44, .86 and .72 respectively; for the Expressiveness subscale came out to be .69, .34, .73 and .70 respectively; and for the Conflict subscale came out to be .75, .43, .85 and .66 respectively (Moos, 1990). In India, this test has been successfully used

by Tung and Jhingan in 2002 (as cited in Chhabra, 2014), Chahal (2003), and Sandhu (2013).

Clinical Assessment Of Interpersonal Relationships (CAIR; by Bracken, 2006): CAIR documents the difficulties that students (ages 9 to 19 years) have in relationships with their mother, father, male peers, female peers, and teachers, through its five scales and Total Relationship Index (TRI). This instrument demonstrates exceptional technical adequacy as a tool, with reliabilities well above .90 for each of the five scales and for TRI (Bracken, 2006). Further, statistically significant correlations have been found between CAIR Scales and – Multidimensional Self Concept Scale (Bracken, 2006), Clinical Assessments of Attention Deficit-Child (Bracken & Boatwright, 2005), Clinical Assessment of Behaviour (Bracken & Keith, 2004), and so on (Bracken, 2006).

Procedure

After screening through CTQ for childhood abuse, two groups of adolescents (one abused and other non-abused group), each comprising 100 adolescents, were formed. To make necessary comparisons on the three criteria of mental health i.e. problem behaviour, perception of family environment, and interpersonal relationships, all the adolescents within these two groups were administered YSR, FES, and CAIR. The scores of both the groups on these measures of mental health were analyzed to investigate the differences in the mental health of abused and non-abused group.

RESULTS AND DISCUSSION

Table 1 shows that means, S.D.s, and t-ratios' between the scores of both groups on YSR, FES (Conflict, Cohesion and Expressiveness subscales) and CAIR. As shown in table, all the five t ratios' came out to be significant ($p < 0.01$), thereby supporting all the three hypotheses of study.

Table 1: Means, S.D.s and t-ratios' of Scores of Abused and Non-Abused Group on YSR, FES (Conflict, Cohesion and Expressiveness Subscales) and CAIR

			Mean		S.D.		t
			Abused group	Non-abused group	Abused group	Non-abused group	
HYP. I	YSR	78.30	30.69	10.83	12.60	28.68**	
HYP. II	FES	Conflict	7.49	2.87	1.11	1.32	27.18**
		Cohesion	2.61	7.36	1.22	1.14	29.69**
		Expressiveness	2.30	7.44	1.11	1.12	32.12**
HYP. III	CAIR	422.37	564.92	81.76	38.89	15.74**	

$t_{.05}(198) = 1.97$; $t_{.01}(198) = 2.60$

This investigation was an attempt to examine if there exist significant

differences in the mental health of adolescents abused during childhood and the adolescents with no such histories. The criteria adopted for taking an estimate of mental health of adolescents were: 'problem behaviour', 'perception of family environment', and 'problems in the interpersonal relations with parents, peers and teachers'. The results obtained from the comparison of scores on the measure of problem behaviour, family environment and interpersonal relations of abused and non-abused groups came out to be significant supporting the three hypotheses of this study. This means that there seems to exist significant differences in the mental health of abused and non-abused adolescents.

There emerged significant differences in the scores of abused and non-abused groups on the Youth Self Report, suggesting that the abused adolescents tend to display more problem behavior (both internalizing: anxious/depressed, withdrawn depressed, and somatic complaints, as well as externalizing: Rule breaking behaviour, aggressive behaviour) than the non-abused group. Earlier studies suggest that childhood abuse seems to have a ripple effect during adolescence. Maltreated children differ significantly from their non-maltreated peers in the domains of externalizing behaviour and internalizing behaviour during adolescence (Pears, Kim, & Fisher, 2008). Research has many evidences which show childhood history of abuse to be related with various other problem behaviours during adolescence, such as a higher probability of running away from home (Kaufman & Widom, 1999); sexually inappropriate behaviours (Gilbert et al., 2009); substance abuse (Perkins & Jones, 2004); criminal behaviour and juvenile delinquency (English, Widom, & Branford, 2004); homelessness (Keeshin & Campbell, 2011); eating disorders (Brewerton, 2007); self-harming (Jacobson & Gould, 2007); and at its worst suicidality during adolescence (Rhodes et al., 2011). Hence, the current study and various empirical evidences of past research suggest that the adolescents with childhood histories of abuse may be considered as either "problem-causing" or "problem-experiencing" adolescents owing to the problem behaviours they generally display.

In the present study also, it was found that in comparison to non-abused adolescents, the adolescents with childhood histories of abuse reported more family conflict and lower family cohesion and expressiveness. A family environment rich in cohesion tends to show high degree of commitment, help and support which the family members provide for one another. A family environment rich in expressiveness tends to show a higher extent to which the family members are encouraged to express their feelings directly. But a family environment rich in conflict shows a higher amount of openly expressed anger and conflict among family members. A healthy family environment necessary for the proper development of children is characterized by lower conflict and higher cohesion and expressiveness amongst family members whereas an unhealthy abusive family environment is characterized by higher conflict and lower cohesion and

expressiveness amongst family members (Moos & Moos, 1994). The victims of childhood abuse generally perceive their families as having higher levels of conflict and lower levels of cohesion (Asgeirsdottir, Sigfusdottir, Gudjonsson, & Sigurdsson, 2011; Meyerson et al., 2002; Turner, Finkelhor, & Ormrod, 2006) and expressiveness (Glaser, 2011; Ryan, Kilmer, Cauce, Watanabe, & Hoyt, 2000). Hence, as suggested by the current study and various empirical evidences from the past research the adolescents with childhood histories of abuse perceive their family environment negatively, suggesting poor interpersonal relationships with their parents.

The findings of this study also suggest that the adolescents with childhood histories of abuse, in comparison to the non-abused group, tend to display more problems in interpersonal relations with parents, peers and teachers. Such children perhaps have started to believe from the very beginning that when parents are not good, how others can be good for them. For them the world is not a safe place and other people are not good for them. Hence the victims of childhood abuse are very likely to enter the teenage and the social world of teenage with cognitive distortions and biases. Abused children have suffered a change in core assumptions about the world and the people in it, making them unable to form newer relationships even during adolescence (Dittmann & Jensen, 2014). Childhood abuse has been found to be associated significantly with relationship difficulties such as difficulties with trust and fear of being different (Hall & Hall, 2011); errors in judgment for interpersonal reasoning situations (DePrince, Chu, & Combs, 2008); and difficulties with social perspective-taking, that lead to a defensive interpersonal style (Burack et al., 2006) thereby creating problematic lifelong relational trajectories (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012). Hence, the current study and various empirical evidences from previous research clearly suggest problems for adolescents with childhood abuse experiences in the domain of interpersonal relationships. The experiences of childhood abuse have made the adolescents to enter their social world with faulty perceptions, faulty self-image and cognitive distortions which have entirely shaped the way they define themselves and their world, thereby affecting badly their interpersonal relationships with significant persons i.e. parents, teachers and peers, in their lives.

Thus it may be concluded that the adolescents with childhood histories of abuse fall lower on the criteria ('problem behaviour', 'perception of family environment', and 'problems in the interpersonal relations with parents, peers and teachers') which are generally considered as the important predictors of any individual's mental health. The study has stressed that the mental health symptoms during adolescence may be due to inappropriate experiences at the previous stage, the effect of which may still be lingering onto the present stage of development. Therefore, the prime or sole focus of concern while considering the adolescent

psychopathology, in terms of their mental health, should not be the current symptoms only, but the underneath past traumas of childhood abuse also.

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BEHAVIOUR PROBLEMS OF MENTALLY RETARDED CHILDREN AS A FUNCTION OF LEVEL OF RETARDATION, SLEEP DISTURBANCES AND CIRCADIAN RHYTHMICITY

Kamal, H* and Hasan, B**

ABSTRACT

The aim of the present research work is to examine the main and interactional effects of level of retardation, sleep disturbances and circadian rhythmicity upon behaviour problems of mentally retarded children. An ex-post facto study using a 2x2x2 factorial design (fixed model) was conducted, where a sample of 230 subjects, within the age ranges of 7 to 12 years, were drawn from male institutionalized mentally retarded children by using incidental-cum-random sampling technique. Behavioural Assessment Scale for Indian Children with Mental Retardation (BASIC-MR, Part- B) was used to measure the behaviour problems. The level of retardation and circadian rhythmicity was found to generate significant variance in behaviour problems of mentally retarded children whereas sleep disturbances did not emerge as a significant factor influencing behaviour problems. The theoretical and practical issues have been discussed.

Keywords: Behaviour problems, Level of Retardation, Sleep Disturbances and Circadian Rhythmicity

Mental retardation is a subtype of intellectual disability which is found in every culture. Mentally retarded children exhibit two types of behaviour which may be classified into skilled behaviour and behavior problems. The behaviours which may become a potential source of danger for the children or the people around them and causes a great strain on caregivers are termed as behaviour problems. The behavior may interfere with the teaching or learning new skilled

* Huma Kamal, Psychiatry Social Worker, Department of Psychiatry, Pt. Jawaharlal Memorial Medical College, Rapur (C.G.)
** Dr. B.Hasan, Professor and Head, SoS in Psychology, Pt. Ravishankar Shukla University, Raipur (C.G.)

behaviour, so the present paper focuses on problematic behavior of these children. Behaviour problems became a matter of concern as it may influence the physical, emotional, social and academic development of child. The mentally retarded children exhibit more behaviour problems than non retarded children (Carr, 1977; Favell et al., 1982). Various studies have shown that there is a wide range of behaviour problems which are common among mentally retarded children and their incidence is relatively higher by 30% to 65% than that in general child population (14% to 25%) (Barkson & Davenport, 1982; Eymana et al., 1981; Quadri, 1993). The behaviour problems appear in various forms such as annoying, getting out of the seat, attention deficit, impulsivity, recklessness, excessive activity, withdrawal, shyness and aggression (Qatami, 1989), aggressiveness, hyperactivity, mood disorder, withdrawal, self injury and stereotyped behaviour are common among mentally retarded children (Kitcher et al., 2005).

There are several factors which influence behaviour problems. Mental retardation- Barron & Sandman (1984); Dave et al., (1993); Dimitropoulos et al., (2001); Einfeld et al., (2001); Finucane et al., (2001); Frank et al., (1994); Freund & Reiss (1991). Intellectual functioning- Finucane et al., (2001); Holden & Gitlesen (2006); Hashino et al. (1997); Johnson, Lubetsky & Sacco (1993); Jolanda et al., (2007); McGrew et al., (1991). Caretakers- Baker et al. (2002); Hastings (1997); Linda et al. (2005); Margalit et al (1989); Michell & Hastings (2001). Psychopathology- Harper & Wadsworth (1990); Holden & Gitlesen (2003); Nuovo & Buono (2007); Reynolds & Miller (1985); Rojahn et al. (2004). Circadian rhythm- Glickman (2009); Monteleone et al. (1997); Piazza, Fisher & Kahng (1996); Richdale & Prior (1995); Sadeh et al. (1995). Sleep disturbances – Cataldo & Harris, 1982; Symons et al., 2000; Didden et al., 2002; Wiggs & Stores, 1996; Quine (1986, 1991); Quine (1999); Lancioni et al., (1999).

Several reports have indicated that behaviour problems of children with mental retardation reflect the operation of multiple risk factors which include parent and sibling adjustment (Cuskelly & Dadds, 1992; Gath & Gumley, 1986), level of mental retardation (Gath & Gumley, 1986) and medical problems (Turner, Sloper & Cunningham, 1990). The relationship between behaviour problems and level of retardation has not been consistently documented in studies. So, in the present study it was decided to incorporate level of retardation as an independent variable. It has been reported that sleep disturbances are more common among mentally retarded children and also more likely to persist (Barlett et al., 1985; Clements et al., 1986 & Quine, 1991) which not only affect them but also those who take care of them (Polemini et al., 2005) while the cause is still only conjecture. A relationship between sleep problems and increased aggression and irritability has also been documented. So, it is justifiable to take sleep disturbance as an independent variable in the present study in order to determine its impact on behaviour problems in mentally retarded children in Indian context. A large

pool of research has been accumulated stating the relationship between 24 hr sleep wake cycle, sleep pattern, sleep disturbances and circadian rhythm. Circadian rhythms are physiological and behavioural processes that have an approximately 24 hr (Glickman, 2010). It is seen that sleep abnormalities represent circadian disturbance in many functions (Patzold et al., 1998, Richdale & Prior, 1995, Wiggs & Stores, 2004, William et al., 2004). There is not even a single study reported in India or abroad which states the causal relationship between behaviour problems of mentally retarded children and circadian rhythm.

So, the problem of the present research work is to investigate empirically whether level of retardation, sleep disturbances and circadian rhythmicity can generate significant variance upon the behaviour problems of mentally retarded children.

It is assumed that there would exist main and interaction effects of three independent variables viz., level of retardation, sleep disturbances and circadian rhythmicity on behaviour problems of mentally retarded children at first and second order level.

METHOD

Sample

Following the stratified-incidental-cum-random sampling technique, a sample of 230 mentally retarded children were drawn for the present study. The number of Ss assigned in each cell of the 2x2x2 factorial design was not equal. All the respondents were male institutionalized mentally retarded children whose age ranges from 7 to 12 years. The data was collected from different states of India viz., Chhattisgarh, Madhya Pradesh, Maharashtra and Gujarat.

Research Design: In the present study, a 2X2X2 factorial design (fixed model) was used to study the main and interactional effects of three variables, viz., level of retardation, sleep disturbances and circadian rhythmicity on the dependent variable, viz., behaviour problems of mentally retarded children. Each of the independent variable was varied at two levels, i.e. mental retardation: mild and moderate; sleep disturbances: without and with and circadian rhythmicity: synchronized and desynchronized.

Tools:

Behavioural Assessment Scale for Indian Children with Mental Retardation (BASIC- MR) Part B: It was employed to assess behaviour problems of mentally retarded children. The scale is constructed and standardized by Peshawaria and Venkatesan (1992). It consists of 75 items grouped under 10 broad domains, viz, violent and destructive behaviour, temper tantrums, misbehavior with others, self injurious behaviour, repetitive behaviour, odd behaviour, hyperactivity, rebellious behaviour, antisocial behaviour and fear respectively. The reliability of

the scale was assessed by using test-retest method. Its inter-rater reliability coefficient is 0.835. The construct validity of the scale was found fairly satisfactory.

Vineland Social Maturity Scale (VSMS): The researcher used the Indian adaptation of Vineland Social Maturity Scale by Malin (1979) meant to measure the social quotient (SQ) of the children. It assesses the child's developmental level in looking after his practical needs and taking responsibility of daily life. This scale consists of 89 items, which is subdivided into 8 categories of behavior viz., self-help, self-help in dressing, self-help in eating, communication, self-direction, socialization, locomotion and occupation.

Gessell Drawing Test: It has been adapted by Verma et al. (1972). It is a performance test which is used to assess performance quotient (PQ) and contains total 14 geometrical shapes and figures. The studies on drawings of children by copying suggest that these figures can be used as rough, simple and reasonable measure of maturation and intelligence in children.

Sleep Disturbances Questionnaire: The Hindi version of sleep disturbances questionnaire (Simonds and Parranga, 1982) was used. It has two sections, where Section 1 is meant for assessing sleep related habit and Section 2 is concerned with the sleep disturbances in mentally retarded children. In the present study section 2, which contained 26 items, was administered to assess the sleep disturbances.

Circadian Rhythmicity Sheet: Circadian rhythmicity of the subject was measured on 3 indices: body temperature, blood pressure and pulse rate. Body temperature was measured by thermometer. Pulse rate was assessed by counting the total number of pulse per minute. Blood Pressure was measured by Sphygmomanometer and both systolic and diastolic blood pressure was taken.

Each child was assessed with all the three parameters for 3 days continuously at regular intervals of 2 hours, excluding sleep time. A software named cosinor rhythmometry (Nelson et al., 1979) was used to observe the circadian rhythmicity whether the subject is having synchronized circadian rhythm or desynchronized circadian rhythm.

Procedure

The stratified-incidental-cum-random sampling technique was used in the present research work, to meet the requirement of 230 subjects in the 2x2x2 factorial design. Initially, a list of male children with mental retardation, age group of 7 to 12 years, was prepared. The behavior problems of the Ss were assessed with the help of Behavioural Assessment Scale of Indian Children (BASIC-MR, Part-B). The final stratification of 8 groups was done as per the norms prescribed by the author of questionnaire. According to research design of the present study samples were categorized into eight strata or subclasses. Further to know

behaviour problems of mentally retarded children, assessment was done on the basis of administration of Behavioural Assessment Scale of Indian Children BASIC (MR) Part-B. The questionnaire was administered individually and scoring was done accordingly to the manual and finally put for statistical treatment.

RESULT AND DISCUSSION

The descriptive statistics (number of respondents, mean and standard deviation scores on Behaviour Problems) have been tabulated in Table 1

Table 1 : Mean and standard deviation scores on Behaviour Problems of Mentally Retarded Children of the various groups

Statistical Properties		Mild mentally retarded children		Moderate mentally retarded children	
		With sleep disturbances	Without sleep disturbances	With sleep disturbances	Without sleep disturbances
Synchronized	N	31	27	29	28
CR	Mean	84.35	78.55	88.19	90.83
	S.D	14.12	7.75	10.53	10.36
Desynchronized	N	29	26	29	31
CR	Mean	88.03	86.74	97.04	91.17
	S.D	8.41	8.19	9.96	9.60

The obtained results were analyses by computing 3 way ANOVA, in order to ascertain the independent and interactive effects of the three variables.

Table 2: Summary of Analysis of Variance of Behaviour Problems

Source of Variation		Sum of square	df	Mean square	F-ratio	Level of significance
Main Effect						
Level of Retardation	(A)	3131.466	1	3131.466	29.33	.01
Sleep Disturbances	(B)	380.946	1	380.946	3.55	NS
Circadian Rhythmicity	(C)	1589.156	1	1589.156	14.88	.01
Two-Way Interaction						
Level of Retardation x Sleep Disturbances	(AB)	53.653	1	53.653	0.50	NS
Sleep Disturbance x Circadian Rhythmicity	(BC)	57.695	1	57.695	0.54	NS
Level of Retardation x Circadian Rhythmicity	(AC)	25.529	1	25.529	0.23	NS
Three-Way Interaction						
Level of Retardation x Sleep Disturbances x Circadian Rhythmicity	(ABC)	607.923	1	607.923	5.69	0.1
Within Treatment						
Total		23696.593	222	106.741		
		1818723.200	230			

Table 2 shows that the obtained F-ratios of main effects of two variables viz., level of retardation and circadian rhythmicity were found to be statistically significant beyond .01 level of confidence. It can be further elaborated that moderate mentally retarded children and children with desynchronized circadian rhythmicity exhibited significantly higher behaviour problems than the mild mentally retarded children and children with synchronized circadian rhythmicity. Hence, the framed hypotheses are accepted. It was also observed that the obtained F-ratio of behaviour problem scale relating sleep disturbances was not found to be statistically significant. So, it can be stated that the main effect of sleep disturbances was not found to generate significant variance upon the behaviour problems. Hence, the hypothesis is rejected. None of the three, two factor interactions, were not found to be statistically significant. However, the interaction between the three factors was found to be significant at .01 level.

Mental retardation is the reduced level of intellectual functioning resulting in diminished ability to the daily demands of the normal environment. It seems apparent from the analysis that the level of retardation has been found capable in influencing behaviour problem. It can be discerned that the group of moderate mentally retarded children exhibits more behaviour problems than mild mentally retarded children. The reason may be attributed to their cognitive deficits or the intellectual functioning. Because of decreased cognitive capacities these children struggle to adapt to the daily demands of the environment and the risk of behaviour problem increases. As the level of intellectual function reduces the ability to adapt to the daily demands of the environment also diminishes. It signifies that as the IQ decreases the ability to adaptability also decreases. A number of researchers show that higher IQ is associated with better personal and social adaptation (Harder & Greenwald, 1992; Greenwald, 1990).

The present result can also be explained by the span theory of intelligence of mental retardation proposed by Denny (1966). The children having mild level of retardation are able to meet the daily demands of the environment and are less prone to stress and frustration. Finally they exhibit less behaviour problems. The present study is consistent with the study of Capone et al. (2006) and Kitchner et al. (2005) who reported that behaviour problems are more prevalent in the moderately mentally retarded children than the mild. The result of the present study is also congruent with the previous findings of other researchers (Buelow et al, 2003; Goodman et al, 1995; National Institute of Health, 1991; Reid & Parsons, 1992).

In various studies, it was seen that sleep disturbances influences the behaviour problems of mentally retarded children. So, it was decided to form two groups of mentally retarded children viz., with sleep disturbances and without sleep disturbance, to find out the influence of sleep disturbances on behaviour problems of mentally retarded children. The present research work revealed that

the sleep disturbances do not influence behaviour problems of mentally retarded children. The reason may be attributed to the nature of school and perception of sleep by caretakers. It is justifiable to say that some of the schools manage the time schedules in sleeping and waking time while other schools do not manage the schedule. Although the differences are evident but it is not upto any acceptable level of confidence. In support to this finding several studies may be cited, e.g. Hering et al., (1999); William et al., (2010). These studies suggested that the caretaker's perception of sleep in children with mental retardation may not always accurately reflect the sleep problems. Even in some of the schools, caretaker themselves sleep during night and may respond inaccurately. It may be an important cause to explain that sleep disturbances are not able to show its effect upon the behaviour problems. Whereas in some of the school caretakers use to awake all the night and reported that children have disrupted sleep.

In the present research work, it was decided to incorporate the factor circadian rhythmicity to examine its influence upon behaviour problems. The circadian rhythmicity of mentally retarded children were categorized into two groups i.e. children with synchronized circadian rhythmicity and children with desynchronized circadian rhythmicity. It was observed that children with desynchronized circadian rhythmicity exhibit more behaviour problems than children with synchronized circadian rhythmicity. The desynchronization in rhythm may be expressed as the result of disturbed sleep. It can lead the children to be more irritable. This irritability may produce intolerance towards the environment. In other words it can be stated that child seems to be inadaptate towards their surroundings. The children with desynchronized circadian rhythm tend to exhibit more in behaviour problems than the children who are having synchronized circadian rhythm. Several studies have reported that the devastating circadian system may influence our other physiological and behaviour patterns (Richdale, 1999), irregular sleep-wake cycle (Richdale & Prior, 1995; Williams et al., 2004; Wiggs & Stores, 2004; Kronauer et al., 1982), reduced level of alertness (Manber et al., 1996; Czeisler et al., 1990; Eastman, 1990; Moore et al., 1983), irritation, dizziness, neurobehavioral functions (Glickman, 2010) and tend to show more behaviour problems. The present study is consistent with the findings of

Hoffman et al. (2005), Liu et al. (2006), Malow et al. (2006) and Schreck et al. (2004). The study is also congruent with the other findings that desynchronization in circadian rhythmicity may lead to intolerance and unadjustability towards the environment (Reinberg et al., 1989), considered as a important factor in decrease waking alertness (Folkard et al., 1995) and impaired performance and worsening mood (Mott et al., 1965). The inability to synchronize one's rhythm to rapidly changing time shifts of environment cues which is attributable to the impaired metabolism and sleep disorder (Czeisler et al., 1982; Folkard et al., 1992; Akestedt et al., 2002, 1995; Michel Brind et al., 1981).

Desynchronization of rhythms or loss of stability of the system and changes to sleep and activity rhythms have been reported (Brock, 1991).

It may be concluded that independent variables namely level of retardation and circadian rhythmicity are able to generate significant variance upon the behaviour problems of mentally retarded children whereas sleep disturbances have not found to generate significant effect on behaviour problems.

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RELATIONSHIP OF COPING STRATEGIES WITH PSYCHOLOGICAL DISTRESS IN KASHMIRI MIGRANTS

Rupan Dhillon* and Saima Hafiz**

ABSTRACT

Psychological distress is a state of emotional suffering characterized by symptoms of depression (loss of interest, sadness, hopelessness) and anxiety (restlessness, feeling tense). Psychological distress is the outcome of the exposure to stressful events that threaten the physical or mental health, the inability to cope effectively with the stressful situations and the emotional turmoil that result from ineffective coping. Migration is conceptualized as a process of movement from one place to another either to settle down permanently or for a prolonged period of time. Research has focused on psychological distress resulting from ineffective coping styles. In this paper an effort is being made to study the relationship between coping style and psychological distress in a sample of 200 Kashmiri migrants. The sample includes equal number of males and females between 14-18 years. Purposive sampling technique has been employed since the aim is to examine the Psychological Distress in Kashmiri migrants. Correlation analysis has been used to study the relationship of the variables. Finding reveals that there is significant negative relationship between psychological distress and coping. This study will be helpful for clinicians, professionals and social workers to combat psychological distress among migrants in order to promote their well being.

Keywords: Psychological Distress, Coping Strategies, Adolescents, Kashmiri migrants, Correlation analysis.

Psychological distress is rarely defined as a distinctive concept and is often embedded in the concept of strain, stress, and distress (Bonanno, 2006). Lerulta (2002) considers psychological distress as the emotional condition that one feels

* Assistant Professor

** Research Scholar, Department of Psychology, Guru Nanak Dev University, Amritsar, Punjab. Email: rupan.oberoi@rediffmail.com, saimahafiz21@gmail.com.

while coping with unsettling, frustrating or detrimental situation. Mirowsky and Ross (2002) conceptualized psychological distress as a state of emotional suffering characterized by symptoms of depression (e.g., lost interest; sadness; hopelessness) and anxiety (e.g., restlessness; feeling tense). There are multiple ways of defining stress throughout the literature in terms of medical, environmental, and psychological models of stress (McNamara, 2000). Medical model defined stress as a state of distress which the individual experiences in response to environmental influences (Selye, 1993). Some amount of distress is essential for human living as it makes us adapt to the prevailing situation. But when the degree of distress exceeds the normal, it increases the vulnerability to the unexpected circumstances.

Psychological distress is the outcome of the exposure to a stressful event and has a great impact on the physical and mental health. Stress shares a strong bond with coping behavior of an individual. When individuals are able to cope effectively with environmental stressors, then they become less susceptible to psychological distress (Ridner, 2004). Psychological distress involves disturbing circumstances which affect social bonding and life styles of individuals to a larger extent (Wheaton, 2007). It is a phenomenon associated with normal emotional reaction to a stressor. It is a non-specific response to unpredictable situation which influences mental health (Dohrenwend and Dohrenwend, 1982).

Stress and coping are regarded as inherent and inevitable aspects of traumatic experiences and processes for those undergoing the process of migration (Kuo Ben, 2014). Stress is an integral part of coping. Coping is defined as a process of constantly changing cognitive and behavioral efforts to manage specific external or internal demands that are appraised as taxing or exceeding the resources of the person, regardless of whether the outcomes of such efforts are positive or negative (Lazarus & Folkman, 1984). According to Lazarus and Folkman's (1984) work, the experience of stress and coping become most salient when individuals are faced with life changes and challenges. Migration is an example of such major life event for migrants. They also assert that individuals facing a stressor of similar nature can have different experiences and reactions. It will depend upon primary appraisal- the extent to which a stressor is viewed as threat and secondary appraisal- the evaluation and assessment of one's resources to the stressor. The secondary level of appraisal refers to coping strategies. These would subsequently impact the person's well being and adaptation. It has been postulated that inadequate coping style is an important factor leading to migrants' distress (Cheung & Spears, 1995).

Coping is categorized as problem- or emotion-focused. Problem focused coping encompasses efforts to define the problem, generate alternatives, weigh the cost and benefits of various actions. They often focus on some aspect of the environment or inward to alter some aspect of self. Emotion focused coping strategies are directed toward decreasing emotional distress. These tactics include

efforts such as distancing, avoiding, selective attention, seeking social support, meditating etc. Therefore unlike problem focused strategies, emotion focused strategies do not change the meaning of the situation directly. Ireland, Brown, and Ballarini (2006) opined that maladaptive coping (avoidant and emotion focused) had a great role to play in the emergence of psychological distress. There are various studies which are of the view that coping predicts variance in stress (Knoll et al. 2005). According to Baron and Kenny (1986), coping significantly predicts distress.

It was further elaborated that the mainstream of research on stress and coping strategies has magnified the role they play in the development of psychopathology for high-risk populations, such as adolescents who are exposed to traumatic experiences of migration (Evans et al. 1998; Gonzales, Tein, Sandler, & Friedman, 2001).

The trends in migration are changing globally. It is predicted that there are approximately 14 million refugees (UNHCR, 2004), in which 23.6 million are internally displaced. Their experiences range from trauma including physical and psychological torture to adjustment problems. Thus, migration is a state of movement which has influenced human existence. Each stage of migration is characterized by a period of distress. Migration is mainly distinguished in to forced migration, reluctant and voluntary migration. Migration of Kashmiri Pandits is forced one which took place in 1990 (Zutshi, 2003). It was summarized by prominent Psychiatrist from Kashmir, Madhosh (2001), that there is an increment in the magnitude of psychiatric disorders during 1990-1994 which have been the highest ever since 1989. It increased from 1762 cases in 1990 to 17,584 cases in 1994. It was documented that more than 800 Pandit children during 1990-1997 had developed acute psychological distress. The migration of Kashmiri Pandits has distressed the life of adolescents to greater extent. Since migration is itself a distressing situation it results in psychological disturbances.

Research by Dingra and Watal (2005) has reveal that Kashmiri Pandits are more vulnerable to negative feelings and stress associated with migration. They are unable to cope with the prevailing situation, particularly adolescents, because they are losing their sense of identity. Another study revealed that psychiatric morbidity (depression, post traumatic disorder and generalized anxiety disorder) was more in Kashmiri Pandit migrants who were staying in camps (Banal et al, 2010). Further, Chari & Chander (2003), have also reported that migration not only disturbs the existence of individual in the context of cultural and structural changes but may include emotional and psychological distress. Dingra and Watal (1995) conducted a study on Kashmiri Pandit migrant children in the age group 8 to 10 years and came to conclusion that the negative feelings and stress are deep rooted in their minds and these have affected them consciously and subconsciously as a result of migration. Keeping in mind the relevant literature, this study aims to study the relationship of coping strategies with psychological

distress in Kashmiri Migrants. These migrants have been taken from the camps of Muthi, Nagrota Jagti and Bantalab. The sample chosen for the purpose is adolescents as adolescence is considered the transitional and vulnerable period. An effort has been made to study the coping strategies of these adolescents and how it is related to distress. The study also aims to analyze gender differences in adolescents on psychological distress and the various dimensions of coping.

Objectives

To study gender differences in coping strategies and psychological distress.

To study the relationship of coping strategies with psychological distress in Kashmiri migrants.

Hypotheses

There will be significant gender differences in psychological distress and different dimensions of coping strategies.

There will be significant negative relationship between coping strategies and psychological distress in Kashmiri migrants.

METHOD

Sample

A total number of 200 adolescent's were taken for the purpose of the study. The sample included equal number of males and females in the age group of 14-18 years. Purposive sampling technique has been employed since the aim is to study Kashmiri migrants. The sample is collected from schools which are especially innovated for Kashmiri migrants in migrant camps situated in Muthi, Jagti Nagrota, and Bantalab. During data collection some queries were made by the subjects and they were told the benefits of the study. Data collection was mostly done in small groups and in schools.

Measures

The following measures were used to assess coping strategies and psychological distress among Kashmiri migrants.

1. **Ways of Coping Questionnaire** (Folkman and Lazarus, 1988) is used in order to identify the thoughts and actions an individual uses to cope with stressful situations. It consisted of 66 items and measures eight types of coping namely confrontive coping, distancing, self controlling, seeking social support, accepting responsibility, escape avoidance, planful problem solving, and positive reappraisal. The respondents have to respond on a 4 point likert scale. The reliability and alpha coefficients of the test ranges from .61 to .79 for each dimension.
2. **General Health Questionnaire** (Goldberg and Williams, 1970) consisted of 12 items which is used to measure psychological distress. The reliability of the scale is 0.87. GHQ-12 is a good predictor of psychological distress, which needs psychological intervention. Each

item is rated on a four-point scale and higher scores indicate a greater psychological distress. It has been reported correlation coefficients varied between .71 and .91.

RESULT AND DISCUSSION

In the present study, inferential analysis (t-test) was used to study gender differences and correlation analysis was used to study the relationship between coping strategies and psychological distress.

Table 1: Mean differences, SD, and t-value of female and male Kashmiri migrants

Variables		N	Mean	SD	T
Psychological distress	Females Males	100100	24.927.7	5.154.18	.42**
Confrontive coping	Females Males	100100	5.904.37	3.172.74	3.6**
Distancing	Females Males	100100	5.854.64	3.272.99	2.7**
Self controlling	Females Males	100100	5.784.55	2.962.81	3.0**
Seeking social support	Females Males	100100	5.644.31	3.172.70	3.1**
Accepting responsibility	Females Males	100100	5.274.19	2.532.44	3.0**
Escape avoidance	Females Males	100100	5.844.58	3.332.86	2.8**
Planful problem solving	Females Males	100100	5.854.39	3.282.72	3.4**
Positive reappraisal	Females Males	100100	5.814.60	3.772.90	2.5*

* $p < 0.05$, ** $p < 0.01$

Gender differences were examined on all the variables using t-ratios. Table 1 shows that means and standard deviation of all the measured variables for both the males and females in the age group 14-18 years. A perusal of the Table 1 shows that there are significant gender differences on the indices of coping strategies and psychological distress. Psychological distress significantly differed in males and females ($t = 4.2$, $p < 0.01$). Results indicate that mean scores of males ($\bar{X} = 27.7$) is higher on psychological distress showing that males experienced more distress than females.

Further perusal of the table shows significant differences on all the dimensions of coping between males and females. On all the variables females have shown higher mean scores, confrontive coping ($= 5.90$), distancing ($= 5.85$), self controlling ($= 5.78$), seeking social support ($= 5.64$), accepting responsibility ($= 5.27$), escape avoidance ($= 5.84$), planful problem solving ($= 5.85$) and positive appraisal ($= 5.81$). It is clearly visible that females are more prone to use these coping strategies than males. Results also suggest that because the females have higher mean score on the coping strategies, they are accessing better coping opportunities in comparison to males, that's why they experience less psychological distress than their male counterparts. Previous studies have reported significant gender differences in coping mechanism among migrants. Females have seen to be utilizing more emotion focused coping as compared to males.

Studies also show that men employed more problem-focused coping strategies than women (Angst et al, 2002; Karanci et al, 1999). Tamres et al (2002) examined gender differences on the indices of coping strategies with psychological distress and found that women make greater use of a variety of coping behaviors compared to men. The results of the study are supported by the underlining phenomena that because of difference in coping mechanism among males and females, males are vulnerable to traumatic experiences of migration. Ben-Zur and Zeidner (1996) compared the coping patterns of males and females and found that women used emotion focused coping strategies where as males make use of problem focused coping.

It is possible that female adolescents mature early and hence develop better coping strategies than male adolescents. They cope better to their existing environment conditions. They have more control over their emotions and are more responsible and equipped to handle their problems. Since male adolescents are more exposed to their social environment than the female adolescents, so a mindset of displacement from their original environment can create a stressful disharmony in their mind leave them distressed. The coping skills are also less enhanced as compared to females which can perhaps result in higher stress.

In such situations the role of parenting is very crucial. However if the parents have not coped to the new environment then the problems tend to increase for their children.

The findings of the study are supported by Cheung and Spears, (1995) who emphasized that inadequate coping styles is a leading factor to migrants distress. The outcomes of the study indicate that emotion and problem focused coping was related to the psychological distress of the Kashmiri migrants.

The relation between psychological distress and coping was analyzed separately for males and females and the earlier analysis had revealed significant gender differences on all the measures.

Table 2: Inter-correlations between coping strategies and psychological distress in female Kashmiri migrants

Emotion Focused		Psychological distress
	Confrontive coping	-.81**
	Accepting responsibility	-.76**
	Escape avoidance	-.73**
	Self controlling	-.75**
Problem Focused	Distancing	-.78**
	Seeking social support	-.74**
	Planful problem solving	-.75**
	Positive reappraisal	-.73**

* $p < 0.05$, ** $p < 0.01$

Table 2 shows a significant negative correlation of psychological distress with confrontive coping ($r = -.81$), accepting responsibility ($r = -.76$), escape avoidance ($r = -.73$), self controlling ($r = -.75$). These strategies are components of emotion focused coping. Similarly components of problem focused coping show significant negative relationships. There is a significant negative correlation of psychological distress with distancing ($r = -.78$), seeking social support ($r = -.74$), planful problem solving ($r = -.75$) and positive reappraisal ($r = -.73$). As evident from correlation coefficients, it can be stated that there is an inverse relationship between coping strategies and psychological distress. Confrontive coping strategy in the females has shown a very strong negative correlation with psychological distress. Thus, development of effective skills to confront and face a stressful situation reduce psychological distress.

Further, negative relationships also show that females are not able to detach themselves from the situation nor are they able to dissolve their inner conflicts because there is emulsification of negative events which have made the prevailing situation more distressful for the female migrants. Due to lack of social support, their efforts to customize the stressful situation are distressing. The influences of environmental factors have made a great impact on the lives of adolescents in recognizing their roles and in turn they put illogical efforts to confront the situation which devaluate their personal growth. The results of the study are supported by Basharat et al., (2014) which signifies that women were more disposed to use emotion focused coping to deal with distress.

Table 3: Inter-Correlation between coping strategies and psychological distress in males Kashmiri migrants

Emotion focusede		Psychological distress
Problemfocused	Confrontive coping	-.38**
	Accepting responsibility	-.42**
	Escape avoidance	-.30**
	Self controlling	-.26**
	Distancing	-.33**
	Seeking social support	-.38**
	Planful problem solving	-.36**
	Positive reappraisal	-.34**

* $p < 0.05$, ** $p < 0.01$

The above table shows a correlation between psychological distress and coping strategies. Psychological distress correlates with confrontive coping ($r = -.38$), accepting responsibility and ($r = -.42$), escape avoidance ($r = -.30$), self controlling ($r = -.30$). These are categorized as emotion focused coping styles. Problem focused strategies also show a negative correlation with psychological distress. Psychological distress correlates negatively with distancing ($r = -.33$),

seeking social support ($r = -.38$), planful problem solving ($r = -.36$), and positive reappraisal ($r = -.34$). The negative correlation suggest that they are unable to recognize their roles to confront with the prevailing situation that result in derailment of their values which directly influence their coping strategies which in return make them psychologically distressed. Studies claim that those who have better coping strategy would have better general health state (Lim, Tam, lee, 2013). Another study in support of our result reports that male experience greater stress than females (Talwar, Kumaraswamy, Mohd Fadzil, 2013). Neil (2007) also stated that the best predictor of psychological distress was use of avoidant coping strategies. It is also suggested that depressed adolescents use more avoidant coping strategies as compared to non depressed students. As females had significantly higher mean scores on all the coping strategies and a lower score on psychological distress, in comparison to males, the present results clearly indicate the efficacy of coping strategies, both emotional as well as problem focuses, in reducing psychological distress.

Therefore, it can be stated that individuals who are unable to develop coping strategies are more psychologically distressed. Since, the sample taken in our study is of Kashmiri migrants who are staying in the camps, it can be suggested that the coping strategies are not that effective, therefore they are unable to cope with stressful situations in their day to day life. The migrants have problems in dealing with their environmental and situational problems

CONCLUSION

From the present study it is evident that there is a significant negative relation of coping strategies with psychological distress in Kashmiri migrants. In the light of the above results it has been found that migrants who lack adequate coping strategies to deal with the various stressors of migration suffer from more psychological distress. Male migrants also scored higher on psychological distress. It can be because they were unable to express their feelings, unable to avoid the situations and had developed feelings of detachment from values, customs and beliefs.

Implications

This study has implications from intervention perspective in terms of management for migrants. Considering the importance of coping strategies in fortifying distress among migrants, Community-based programs should be initiated that reduce isolation and facilitate the development of social networks that reduce the gap among individuals from their own culture. It is necessary for the mental health professionals to design strategies that focus on the Kashmiri migrant's well-being. Coping can be used as a powerful tool which helps in confronting stressful situations and makes them adaptable to the environment. Therefore the professionals, clinicians should plan treatment and management strategies for this particular community keeping in mind that coping skills are strengthened. Some

strong initiative should be taken so that wellbeing is strengthened in the schools. Counseling sessions can be a part of the school's curriculum for such students.

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SUICIDAL IDEATION AMONG ADOLESCENTS: A QUALITATIVE ANALYSIS OF TRIBAL, GOVERNMENT AND CORPORATE SCHOOLS

J. Ashok and P. Swathi***

ABSTRACT

The present investigation aimed at studying suicidal ideation among the adolescent students of government, corporate and tribal high schools. The sample consisted of 410 adolescents/ students (boys & girls) studying in class 10th. A sample of 50 was selected in Eturunagaram, a tribal region (This school was established for those who live in tribal area in Warangal District, Erstwhile Andhra Pradesh). Similarly, a sample of 120 was selected from three government high schools and a sample of 240 from 3 corporate schools. The method of sampling used in this study is random sampling. The selected adolescents were in the age group of 14 - 17 years and hailed from all categories of socio - economic status. The Suicide Behaviors Questionnaire Revised (SBQR) was used to assess Suicidal Ideation and behavior in the sample. The results are discussed in detail in the paper.

Keywords: Suicidal Ideation, Suicide attempt, Suicidal behavior, Adolescents

In this competitive world with scientific and technological changes on soaring, we need to keep pace with these changes. Thought present era is a scientific era, where lot of material prosperity has been increasingly gained, but discoveries of the scientist have broken our traditional beliefs and values systems. It is our youth especially who are the victims of this transition from traditional to the modern western society. They are increasingly going restless. They want change and are not sure of the direction of the change. So today with the type of changes all over the globe and particularly in our Indian society, this will play a major role in changing adolescent's way of thinking which will eventually lead to change in their behavior.

* Department of Psychology, Osmania University, Hyderabad, Telangana.

** Department of Psychology, Osmania University, Hyderabad, Telangana.

Adolescents have various problems and one of them being adjustment. The educational and social environment is among the factors creating problems for adolescents. Society is not able to catch up with modernism in its constructive aspects and its traditions have brought about a conflict of values and created frustrations among youth giving rise to many serious problems. Most of the adolescents are over sensitive and unable to cope with life frustrations. Due to this, their level of anxiety and stresses are on raise leading to depression and eventually resulting into suicidal tendencies.

- **Suicidal ideation:** It describes thoughts, fantasies, ideas or images related to committing suicide. This term is also sometimes referred to *suicidal thinking*. Active suicidal ideation is when a teen experiences persistent thoughts of suicide and continuously feel hopeless. When the ideation is active, a teen begins to take steps to carry out a suicide attempt. Suicidal ideation in teens is often caused by untreated depression or drug abuse, and always needs to be taken seriously. Past suicidal behaviors are a significant factor for suicide. About 50% of those who died of suicide had made at least one previous attempt. The presence of current suicidal ideation plans and attempt are associated with a high risk of suicide.
- **Individual History:** It plays an important role in suicidal attempts. This includes medical conditions like malignancies, heart disease, HIV/AIDS, chronic obstructive lung disease, etc. Other factors include psychosocial stressors, family history of suicide and mental illness.
- **Personality Strength and Weakness:** This relates to lack of coping skills, lack of problem-solving skills, pessimism, hopelessness perfectionism, illness.
- **Suicide Risk Assessment:** Clinicians should endeavor to perform a comprehensive suicide risk assessment on any patient who expresses suicidal tendencies such as ideation, thought, intent or attempt and more especially, when they portray some of the risk factors discussed.

The goals of the assessment are to identify individual suicide risk and the protective factors in order to estimate severity of suicide risk, and help the individual gain insight into his or higher motivation for suicide, to identify modifiable factors, and to target interventions to reduce the suicide risk.

Assessment of Suicidality

There are four main steps in assessment of suicide risk:

- Establishing a therapeutic rapport with patient, showing empathy and using gentle enquiry about suicidal behavior.
- Acquiring collateral information from relatives, friends, or significant others, because some patient's might give inaccurate information about the incidence to downplay the act.

- Assessing current suicidal ideation, intent and plan. This includes the method, availability of means, patient's belief about lethality of the method, chance of rescue, steps take to enact plan, and preparedness for death.
- Assessing the motivation for suicide such as anger, escape from suffering; wish to reunite with loved ones, hopelessness, loss of relationship, etc.

It is important to take the subject of suicide seriously. It doesn't seem right that a teenager - who has lived for such a short time - would choose to die. But adolescents who can't get over their depression sometimes do kill themselves.

Boys commit suicide more often than girls, but no one is immune. In one recent survey of high school students, 60 percent said they had thought about killing themselves. About 9 percent said they had tried at least once.

According to Friday, J.C., (1995) suicide is the eighth leading cause of death for all persons regardless of age, sex or race; the third leading cause of death for young people aged 15 to 24; and the fourth leading cause of death for persons between the ages of 10 and 14.

In a recent study conducted by Mullen, P.E (1996) on the long-term impact of child abuse, adult women who said they were physically or emotionally abused as children were more likely to have mental problems, suffer from depression and to have attempted suicide.

The youth suicide rate gone so high in recent years because of the following factors:

- It's easier to get the tools for suicide (Boys often use firearms to kill themselves; girls usually use pills)
- The pressures of modern life are greater
- Competition for good grades and college admission is stiff and
- There's more violence in the newspapers and on television.

Lack of parental interest may be another problem. Many children grow up in divorced households; for others, both of their parents work and their families spend limited time together. According to one study 90 percent of suicidal teenagers believed their families did not understand them. However, this is such a common teen-age complaint that other factors are playing a role, too. Young people also reported that when they tried to tell their parents about their feelings of unhappiness or failure, their mother and father denied or ignored their point of view.

A troubling study (2008) in the September 3rd Journal of the American Medical Association raises new concerns about kids committing suicide. After a one year spike in the number of suicides, doctors were hoping to see more normal numbers in the latest study, but they didn't. The number of kids committing

suicide in the U.S. remains higher than expected, and that has doctors and parents looking for answers.

A far greater number of teens consider taking their lives each year. Survey data from 1999 indicate that 19.3 percent of high school students had seriously considered attempting suicide, 14.5 percent had made plans to attempt suicide, and 8.3 had made a suicide attempt during the previous year. The Substance Abuse and Mental Health Administration released data on September 12, 2005 showing that 900,000 youth planned suicides during an episode of major depression, and 712,000 attempted suicide during such an episode.

A study conducted by Kimberiy A. Schwartz (2010) revealed that parents and teens believe suicide isn't a problem in their communities. Researchers conducted focus groups with parents and teens living in urban, suburban, or rural areas in an effort to better understand their attitudes and perceptions regarding adolescent suicide. They found that parents and teenagers were able to identify many of the most common risk factors for suicide, including depression, alcohol and drug abuse, and relationship problems. But both groups also tended to underestimate the risk in their own backyards, believing instead that it was a problem in other communities. "The thinking was that it might happen over there, but it doesn't happen to us." Teens and parents underestimated teen suicide risk.

Identifying at-Risk Teens

In U.S. (2006), 1,771 children and teens between the ages of 10 and 19 committed suicide. Folkenberg, J. (1990) found that teenage boys were four times as likely as teenage girls to die by suicide and they were also more likely to use guns and suffocation to kill themselves. Girls were more likely than boys to use pills.

Schwartz (2010) says many of the parents who participated in the focus groups expressed frustration about distinguishing between true warning signs of suicide and normal teen angst. They recognized that guns and potentially lethal medications should be secured or removed from the homes of teens who are at risk for suicide, but acknowledged that they may have difficulty identifying those teens.

Suicide Rate of Indian Teens

The highest suicide rate in the world has been reported among young women in South India by a new study (2004). The research is of major importance, according to the World Health Organization, as it brings to light Asia's suicide problem. The average suicide rate for young women aged between 15 to 19 living around Vellore in Tamil Nadu was 148 per 100,000. This compares to just 2.1 suicides per 100,000 in the same group in the UK.

The global suicide rate stands at 14.5 deaths per 100,000, with suicide the fourth leading cause of death in the 15 to 19 age group. However, in the Tamil Nadu study, suicide was the number one cause of death among these adolescents.

Notably, young women were much more likely to kill themselves than young men – the reverse of the rest of the world. In Western countries, men are three times more likely to commit suicide than women.

Suicides accounted for between 50 and 75 per cent of all deaths in adolescent girls and about a quarter of all deaths in boys aged 10 to 19. Hanging was the most common method used, followed by poisoning using insecticide.

Bertolote, J. (2004) points out stress factors that affect Indian women in particular, such as issues of marriage and dowry. Even one common suicide method is almost unique to Indian women, that of self-immolation. Sacrificing oneself on a fire was the third most frequent method of suicide recorded in the study and was carried out exclusively by girls.

Objective

- To explore the suicidal tendencies/ ideation among adolescents.
- To study the presence of suicidal ideation among the adolescent students of government, corporate and tribal high schools.

METHOD

Tool

The Suicide Behaviors Questionnaire Revised (SBQR): The Suicide Behaviors Questionnaire Revised is developed by Osman A, Babbe CL, et al (2001). It has 4 items, each tapping a different dimension of suicidality. Item 1 taps into life time suicide ideation and suicide attempt. Item 2 assesses the frequency of suicidal ideation over the past twelve months. Item 3 assesses the threat of suicide attempt. Item 4 evaluates self reported likelihood of suicidal behavior in the future.

Sample

The sample for the present study consisted of 410 adolescents studying X class students. It includes both genders. A sample of 50 was selected in Eturunagaram, a tribal region (This school was established for those who live in tribal area in Warangal District, Erstwhile Andhra Pradesh). Similarly, a sample of 120 was selected from three government high schools and a sample of 240 from 3 corporate schools. The method of sampling used in this study is random sampling. The selected adolescents were in the age group of 14 - 17 years and hailed from all categories of socio - economic status.

Procedure

First, the investigator identified the government schools and corporate schools that exist in Hyderabad. From this list, he randomly selected 3 government high schools and 3 corporate schools. One tribal school was also selected from Warangal District.

The investigator established rapport with the school authorities and briefed them about the research that aimed at identifying suicidal tendencies among adolescents.

Then the investigator developed the rapport with the students of government high school and administered the Suicide Behaviors Questionnaire with the following instructions— "Read carefully the following statements. For each statement, there are certain options. Whichever you feel suitable to you, mark that statement." After the completion of the questionnaire, the responses are scored as per the manual. The same procedures are followed with the sample of corporate schools and tribal school.

RESULTS AND DISCUSSION

The study on Tribal schools indicated an interesting finding that 22.7 percentage of boys felt the idea of killing one self for a brief movement, and they also attempted to kill themselves but did not really want to die. On the other hand, another 22.7 percentage of students felt that they really wanted to die, and expressed the probability that they may attempt suicide some day. 18.2 percentage of students in these schools at least once got the idea of killing one self in the past one year, and 13 percentage of them at least once told someone that they are going to commit suicide but did not really want to die. This is quite interesting as tribal students outwardly did not experience much of the suicidal symptoms but suicidal ideation is present to a larger extent.

Table-1: Presence Of Suicidal Ideation Among Adolescents in Tribal Schools (N=50)

<i>Suicidal Ideation</i>	<i>Percentage</i>
Idea of killing one self for a brief movement, and they also attempted to kill themselves but did not really	22.7%
They really wanted to die, and expressed the probability that they may attempt suicide some day.	22.7%
At least once got the idea of killing one self in the past one year	18.2%

Table -2: Presence Of Suicidal Ideation Among Adolescents in Corporate Schools: (N= 340)

<i>Suicidal Ideation</i>	<i>Percentage</i>
Idea of killing one self for a brief movement, and they also attempted to kill themselves but did not really want to die.	4% of Boys
Had a plan of at least once to kill themselves, but did not try to do it.	5.5% of Boys
Had thought of killing one self in the past year at least once.	6.6% of girls & 6.8 % of boys
Told some one, that they may commit suicide but did not really want to die.	9.6% of Boys

When the research was conducted on adolescents who are studying in corporate schools, the result revealed that compared to girls, 4 percentage of boys had a brief passing thought of killing one self. Similarly 5.5 percentage of

boys had a plan of at least once to kill themselves, but did not try to do it. It is also found that in contrast to 6.6 percentages of girls 6.8 of boys had thought of killing one self in the past year at least once. It is also noticed 9.6 percentages of boys told some one, that they may commit suicide but did not really want to die. However it is noticed that not significant percentage of students expressed the probability of committing suicide someday. Here, too, the symptoms are not experienced by boys to a larger extent but they possess the suicidal ideation. In corporate schools compared to girls, boys exhibited more of suicidal ideation.

Table -3: Presence of Suicidal Ideation Among Adolescents in Government Schools (N=120)

<i>Suicidal Ideation</i>	<i>Percentage</i>
Idea of killing one self for a brief movement, and they also attempted to kill themselves but did not really want to die.	3% of boys & 9.2% of girls
Had a plan of at least once to kill themselves, but did not try to do it.	10.4 %of boys
Had thought of killing one self in the past year at least once.	1.3 % of boys & 6.1 % of girls
Told some one, that they may commit suicide but did not really want to die.	5.2 % of boys & 13.3 % of girls
They may attempt suicide someday	6.1 % of girls & 1.3% of boys
Rather likely or very likely to attempt suicide someday.	4% of girls

The research conducted in government schools on boys and girls revealed the following facts about suicide ideation. In contrast to 3 % of boys, 9.2% of girls had a brief passing thought about killing oneself. On other hand, 10.4 % of boys had plan at least once to kill oneself but did not want do it. Compare to 1.3 % of boys, 6.1 % of girls had the thought of killing one self in the past one year at two times. In contrast to 5.2 % of boys, 13.3 % of girls at least one time told someone that they would commit it suicide but not want to die. 6.1 % of girls studying in government schools felt they may attempt suicide someday, compared to 1.3% of boys. Similarly 4 % of girls are rather likely or very likely to attempt suicide someday. Girls in government schools expressed more of suicidal ideation compared to boys in government schools.

CONCLUSIONS

1. Tribal boys expressed high suicide ideation.
2. Boys in corporate schools possess the suicidal ideation though not many symptoms are experienced by boys compared to girls.
3. Girls in government schools expressed more of suicidal ideation compared to boys in government schools.

Suggestions for Further Research

1. The present study can expand into different areas of the state which facilitates a larger sample for effective generalization of the results.
2. Socio demographic factors like age, income and religion can also be considered.
3. Awareness programs and intervention programs can be designed and experimented effectively.
4. As adolescents are found to be vulnerable, irrespective of the gender and nature of school, it is essential to design suicidal prevention programmes at school and college levels.
5. Suicide Screen programmes have to be conducted at the school, college and community level to identify those at high risk and to provide timely help.
6. Life Skills Programmes for youth have to be promoted to develop their resilience and to inculcate positive attitude among them.

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IMPACT OF BODY IMAGE ON SELF-ESTEEM AMONG ADOLESCENTS

Eulalia Almeida and Shivakumara K.***

ABSTRACT

The primary aim of the present research is to study the impact of body image on self esteem among early, middle and late adolescents; and to examine how the relationship between body image and self-esteem may vary as a function of age. The Multidimensional body-Self Relations Questionnaire (MBSRQ) by Thomas F. Cash and the Rosenberg's Self-esteem scales were administered on a sample of 120 adolescents to measure the body image construct and self-esteem respectively. The sample was further sub-divided into 3 groups of 40 adolescents each belonging to early (11-13 years), middle (14-16 years) and late (17-19 years) adolescence. The data was analyzed using t-test to assess whether adolescents with positive and negative body image differ in their self-esteem; and the ANOVA was computed to examine whether the three groups of adolescents differed in their self-esteem. Results obtained revealed that adolescents with positive body image had significantly higher levels of self esteem as compared to those with negative body image. Besides, findings of the study indicate that among the early, middle and late adolescents, the late adolescents have higher self-esteem and early adolescents were found to have lower levels of self-esteem.

Keywords: Body Image, Adolescents, Self-esteem

Adolescence is a developmental stage of a human being in which the process of biopsychosocial maturation occurs intensively (Papalia & Feldman, 2013). The transition between childhood and adulthood is often described as a time of turbulence and stress for young people. However, most research suggests that

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- * Research Scholar, Department of Post-Graduate Studies and Research in Psychology, Karnatak University, Dharwad.
- ** Associate Professor, Department of Post-Graduate Studies and Research in Psychology, Karnatak University, Dharwad.

this "storm and stress" view of adolescence is exaggerated (Conger & Galambos, 1997). It is noteworthy that, although every adolescent goes through these fundamental changes, the interpretation and impact of these changes are very much dependent on the context in which the adolescent develops (Steinberg, 2011).

Different researchers have defined the age range of adolescence differently. While some researchers define adolescence as synonymous with the teenage years, that is, the period between the ages of 13 and 19 years (Nielsen, 1996), others suggest that adolescence has lengthened in the twentieth century. The World Health Organization (WHO; 2005) adopts the chronological criteria, defining adolescence as the life span from 10 to 19 years, 11 months and 29 days. It can be divided into three periods: early (10–13 years), middle (14–16 years) and late (17–21 years) adolescence.

During the periods of adolescence, morphological changes occur in both sexes. Such sudden changes in physical appearance may influence adolescents' assessment of their body image, which is a multidimensional construct involving the accuracy of the perception that the person has regarding body shape and size, along with the feelings this representation may cause (McCabe & Ricciardelli, 2004). Body image can be defined as a person's perception, attitude, and feeling about his or her body (Grogan, 2008). A person's body image may be positive or negative, or anywhere in between. Body image may change depending on contextual cues and over the course of life, though it seems to be fairly stable during adolescent and adult life (Tiggemann, 2004; Wertheim & Paxton, 2012). Body image concerns may be manifested in many ways, ranging from a mild preference for other body characteristics, to pathological body image disturbances such as eating disorders or muscle dysmorphia (a pathological preoccupation with muscularity; Pope et al., 2005). In addition, body image concerns can be about the appearance of the total body (e.g., shape, muscularity, weight, or size) or, alternatively, about specific characteristics or parts of the body (e.g., facial characteristics, hair, body parts, fitness, and strength; Wertheim & Paxton, 2012).

Beauty and physical attractiveness have always been highly valued human attributes, assumed to be connected with happiness, intelligence, and success (Rennels, 2012). Adolescents, who are at a stage in life in which their bodies, minds, and social lives are changing dramatically, are particularly vulnerable to the messages conveyed by appearance culture (Wertheim & Paxton, 2012). While young children may experience body image concerns (Smolak, 2011), these concerns become increasingly common in adolescence (Levine & Smolak, 2002; Lunde, Frisén, & Hwang, 2007). Previous research has shown that as many as 70% of adolescent girls and 50% of adolescent boys are dissatisfied with their bodies and want to change the way they look (McCabe & Ricciardelli, 2001; Wertheim & Paxton, 2012).

Body Image

Body image can be defined as a person's perception, attitude, and feeling about his or her body. Positive body image or healthy body image is marked by realistic perception and acceptance toward the individual's size and shape. In contrast, negative body image or unhealthy body image comprised of shame, embarrassment, disappointment or anxiety about how the individual looks, and people who are categorized into this group may not have a realistic understanding of their body size and shape (Shepphird, 2010; Reynaga-Abiko, 2011).

Self-esteem

Self-esteem can be defined as an evaluative element of how a person values, supports, approves or disapproves him or herself (Frost & McKelvie, 2005). Self-esteem represents a global sense of self-worth and self-acceptance and is an overall emotional response to self-evaluation. Self-esteem is how much one values one's self as a person (Harter & Whitesell, 2003). An overall self-attitude that permeates all aspects of life, high self-esteem carries the implication that one will be accepted, as opposed to rejected by others (Wrosch & Scheier, 2003). A body of research has found that high self-esteem is associated with life satisfaction and psychological health (Heatherton & Wyland, 2003). According to Rosenberg (1965), high self-esteem indicates a personal sense of self-worth and self-respect, whereas low self-esteem implies self-dissatisfaction and self-rejection. While high self-esteem may be associated with an overall sense of well-being, low self-esteem may be related to risk behaviours and negative developmental outcomes (Connor, Poyrazli, Ferrer-Wreder and Grahame, 2004).

The prevalence of adolescent experience of negative body image is indeed worrying. To be unable to reconcile with one's body, to condemn it or to hate it, oppresses people in their everyday lives (Ghaderi & Parling, 2009). Body image is closely related to self-esteem. Frost and McKelvie (2005), define self-esteem "as the level of global regard one has for the self". Self-esteem refers to an evaluative element of how a person values, likes, approves or disapproves him or herself (Frost & McKelvie, 2005). Body image has an important influence upon adolescent self-esteem (Harter, 2003). However, for some young people, satisfaction with their physical appearance plays a critical role in this developmental process and becomes the central determinant of their sense of self. A negative body image is connected to low self-esteem (O'Dea, 2012). The relationship between self-esteem and body dissatisfaction among adolescents overall is fairly strong (Thompson & Smolak, 2001)), and the focus on appearance in making self-evaluations has been implicated in the low levels of self-esteem often observed in adolescence (Robins & Trzesniewski, 2005). Nevertheless, it is likely that self-esteem is not equally strongly tied to body dissatisfaction for all adolescents. For example, associations might also be expected to be stronger at ages in which appearance-related concerns are highest. Thus, it is important to identify variation

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in the body dissatisfaction/self-esteem relationship across ages. Since the association between body dissatisfaction and low self-esteem is unclear, the present study attempts to examine this relationship. Hence the present research aimed to study the impact of negative and positive body image on self esteem of adolescents and attempted to find the differences among early, middle and late adolescents as far as their self esteem is concerned.

Objectives

1. To study the impact of negative and positive body image on self esteem of adolescents
2. To find the differences among early, middle and late adolescents as far as their self esteem

Hypotheses

1. There would be significant difference between adolescents with negative and positive body image in their self-esteem.
2. There would be significant difference among early, middle and late adolescents in their self-esteem.

METHOD**Participants**

A total of 120 adolescents were selected for the study on the basis of convenient sampling technique. The sample was further divided into three groups; namely, early adolescents (11-13 years), middle adolescents (14-16 years) and late adolescents (17-19 years); comprising of 40 adolescents in each group. The participants were selected from various middle schools, higher secondary schools and colleges in Goa.

Tools

Body Image Questionnaire: The Multidimensional Body-Self Relations Questionnaire (MBSRQ) by Thomas F. Cash (2000) was used to measure body image perceptions of adolescents. For the purpose of the study, two sub-scales, namely, Appearance Evaluation (AE) and the Body Areas Satisfaction Scale (BASS) were used to measure body image perceptions as both these are body-image evaluation indices; and are highly correlated (typically .7 to .8). The MBSRQ is intended for use with adults & adolescents. The MBSRQ has been used extensively & successively in body-image research. The Cronbach's alpha and test-retest reliability of the sub-scales ranges from .70 to .94.

Self Esteem Scale: The 10-item Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965) was used to provide a measure of global evaluation of self worth. The RSE is the most widely used instrument for the measure of this construct. Participants are asked to respond by rating how strongly they agree with each statement on a four point scale, using anchors of "strongly agree" to

“strongly disagree”. Scores range from 10-40, with higher scores indicating higher self esteem. The internal reliability coefficient is 0.85

A general Proforma was used to collect demographical information.

Data Analysis

The data were scored according to the keys, and the obtained raw scores were transformed into standard scores (T). The two extreme groups with negative and positive body image have emerged with the application of median for the body image scores. Further, for these two extreme groups of adolescents with negative and positive body image the significance level was determined using t test. The above analysis is done with the help of the SPSS package (17. Version).

RESULTS AND DISCUSSION

A close inspection of Table 01 reveals that the two groups of adolescents with positive body image and with negative body image differ significantly from each with respect to their self-esteem. Adolescents with positive body image are found to have a higher self-esteem as compared to those with negative body image ($t=2.26$; $P<0.05$). The present results support earlier research findings which imply that negative body image is linked to low self-esteem (O’Dea, 2012). Besides, Thompson and Smolak, (2001) have reported that the relationship between self-esteem and body dissatisfaction among adolescents overall is fairly strong. This is probably because, during adolescence, which is a critical phase involving dramatic changes in ones appearance, individuals place great importance to messages conveyed by appearance culture, thereby assessing their self-worth and esteem based on their appearance evaluation.

Table 1: Means SDs and t-values for self-esteem scores of negative and positive body image of adolescents

Variable	Adolescents with Negative Body Image (N=63)		Adolescents with Positive Body Image (N=57)		t-value
	Mean	SD	Mean	SD	
Self-esteem	46.25	8.345	49.44	8.871	2.26*

* $P<0.05$

Table 2: Means and SDs for the scores of self-esteem scores of early, middle and late adolescents

Variable	Sample Groups					
	Early Adolescents		Middle Adolescents		Late Adolescents	
	Mean	SD	Mean	SD	Mean	SD
Self-esteem	42.80	8.17	49.40	6.74	51.09	9.26

Table 3: ANOVA details and mean difference for the self-esteem scores of early, middle and late adolescents

Variable	Df	F-Ratio	Multiple Comparison	M D
Self-esteem	2	12.00***	Early Adolescents – Middle Adolescents	6.61**
	117		Early Adolescents – Late Adolescents	8.29***
			Middle Adolescents – Late Adolescents	-1.69 ^a

P<0.01 *P<0.001

Table 2 reveals that late adolescents have shown above average levels of self-esteem, whereas, early adolescents and middle adolescents have shown below average scores in self-esteem. This could probably be due to the fact that by the time an individual reaches late adolescence, he/she develops an identity and learns to accept one's appearance. During this time the focus shifts from self to one's career. However, during earlier years, adolescents place a lot of significance on appearance, equating it to one's self-worth. Thus, the results may be attributed to these reasons.

Further, a glance at Table 3 reveals that the three groups of adolescents namely, early, middle and late differ significantly among themselves with regard to self-esteem. More specifically, the difference in self-esteem between the three groups is very highly significant ($P<0.001$) with an F ratio of 12.00. In addition, multiple comparison test results have thrown light on difference between the groups at all possible comparisons. The obtained result (Table 03) reveals that the two group of early and middle adolescents show highly significant difference in their self-esteem ($MD=6.61$; $P<0.01$). Very high significant difference in self-esteem has been found between early and late adolescents ($MD=8.29$; $P<0.001$). However, with respect to self-esteem among middle and late adolescents no significant difference is evident. According to Keel et al. (2007) younger individuals generally tend to have a greater degree of dissatisfaction, because the younger adolescents place more self-worth on outer appearance. As a person ages, self worth is determined more by successes in life (Keel et al., 2007). This could probably explain the trend in present results obtained, as early adolescents value appearance more and hence associate their self-worth and esteem with physical appearance. But, as adolescents age and mature, the focus shifts towards identity formation and niche building. Thus, middle and late adolescents have higher self-esteem as compared to early adolescents. The findings obtained are consistent with earlier findings (Harter, 1990) that, in early adolescence, physical appearance tops the list of factors that determine global self-esteem.

However, previous research on self-esteem development in adolescence has yielded inconsistent findings; for example, in some studies self-esteem increased during these years (Huang, 2010; Pullmann et al; 2009), whereas in other studies self-esteem did not change (Chubb et al; 1997; Young and Mroczek, 2003) or

even decreased (McMullin and Cairney, 2004; Zimmermann et al; 1997). The present results suggest that early adolescence is a critical period in self-esteem development and therefore, might be of particular importance for interventions aimed at improving self-esteem.

CONCLUSIONS

1. Adolescents with positive body image are found to have a higher self-esteem as compared to those with negative body image.
2. There is a highly significant difference in self-esteem between early and late adolescents; as well as early and middle adolescents, the late adolescents tend to have a higher self-esteem than early and middle adolescents.

Limitations

There are some limitations of this study. Subjects chosen to participate were not randomized. Another limitation resulted from the size of the sample. With a lower sample size, statistical results may not be found for key relationships. Therefore the data gathered in this study may not be generalizable to the whole population of early, middle and late adolescents in Goa.

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PREVALENCE AND PATTERNS OF PROBLEM BEHAVIOR IN SCHOOL GOING CHILDREN

Bharati Roy*

ABSTRACT

The present work investigated the incidence and pattern of problem behavior in school students. It was planned to examine the variation in problem behavior as related to gender and socio-economic status. It was hypothesized that behavioral problems will be prevalent in school going children of Ranchi and there will be significant difference in prevalence and nature of behavioral problems according to gender and socio-economic status. The sample consisted of 858 adolescents (520 Male and 338 female), age range between 12 to 14 years, belonging to high and low socio-economic status, selected by purposive sampling technique from different high schools of Ranchi (Jharkhand). Revised problem checklist developed by Herbert Quay and Peterson (1980) was used to collect data. The data was statistically analyzed with the help of SPSS Version 10. The data have been analysed according to the aims and hypotheses of the research. Scoring was done according to the respective scoring keys. The results indicated that incidence of behavioral problems in adolescents was found to be 9.07%, anxiety withdrawal was the most common problem observed in these subjects, followed by attention problems. The incidence of problem behavior was higher in females. Anxiety withdrawal was found more in females and attention problem was found more in males. The difference between both sexes was found to be statistically significant. Behavioral problems were found to be more prevalent in students belonging to low socio-economic status than high socio-economic status.

Keywords: Problem behavioral socio-economic status, Purposive sampling, Anxiety withdrawal, Attention problems.

A child's behavior may be a problem if it does not match the expectations of the family or if it is disruptive. Normal or good behavior is usually determined by whether it is socially, culturally and developmentally appropriate. According

* Professor of Psychology, Ranchi University, Ranchi. Contact No. : 09430789030
Email : bharatiroy.roy15@gmail.com

to Achenback (1995) behavioral problems are symptom clusters that are dysfunctional, excessive, maladaptive or debilitating. When an individual's behavior is typical for a particular age and leads to poor adjustment it may be considered as 'problem behavior'. Adolescents are at high risk for the development of problem behaviors that are distressing and socially disruptive. Behavior problems are commonly seen in children and adolescents of all ages. Identifying problem behavior is a complex matter, which depends on several factors including development stage, temperament, home environment, parental separation, family conflict etc. Since normal and abnormal behaviors are considered to be on a continuum, any child may be more or less problematic only with regard to particular characteristics, (Sood & Mishra, 1999). A number of theoretical formulations have been advanced to explain the origin and nature of behavior problems in childhood. These have included the constitutionalists view in which the symptom disturbances are considered to be the direct expression of a predetermined constitutional pattern in the child, the psychoanalytic view in which disturbance is seen as the outcome of conflicts between instinctual drive seeking expression and satisfaction and repressing forces seeking to inhibit or contain them, the learning theory approach in which symptoms are viewed as conditioned maladaptive learned patterns based on conditioned reflex formations and the culturist view in which symptoms are considered to be the more or less direct expression of socio-cultural influences.

Problem behavior in children and adolescents are those that are experienced as troublesome by adults (such as parents and teachers) or, are known to disrupt normative social development to be judged relative to the age of the child. When a child's behavioral difficulties are prolonged, extreme and potentially harmful or dangerous this may be a sign that the child is at risk of or is displaying behavior disorder. The review of available research on behavioral problems in children report a high prevalence rate of behavior disorder (Rutter, et al. 1976; and Graham, 1976). Bower (1981) estimated that about ten percent of school age adolescents are emotionally handicapped. Prakash et al. (2006) conducted a study to find out behavioral problems in children. Result of this study showed 40% of children were having behavioral problems. Sex had no influences in problem behavior. Tirkey and Jahan (2007) in their study found that prevalence of behavior problems was 5.17%. Highest prevalent problem was socialized aggression (2.58%) followed by anxiety withdrawal (1.72%). Least prevalent problem was Psychosis (0.86%).

Incidence of conduct disorders like aggression, attention problems, demanding behavior and restlessness have been reported to be higher among boys. Many studies have reported declining trends in behavioral problems with increase in chronological age (Dagar and Singh, 1981). In a study Rahi (2005) observed that children having behavioral problems mostly were from the high income group, which is significantly high ($P < 0.01$) than the other two economic groups. According to Rohner and Britnar (2002), Parental rejection appears to be a major

predictors in almost all forms of behaviours problems in children and adolescents including conduct disorder, aggressive behavior, externalizing behavior and delinquency (Khalique, 2003.). A number of longitudinal studies show that parental behavior specially rejection tend to precede the development of behavior problems. (Salama, 1984; Ajdukovic, 1990; Al. Falaij A. 1991; Farrington and Hawkins, 1991; Saxena, 1992; Pedersen, 1994; Maughan, Pickles and Quinton 1995 and Chem Robin and Li, 1997). The need for identifying childhood behavioral problems at the earliest is very important to bring about a healthier world for the children of tomorrow. Though a number of prevalence studies of behavioral problems in school children have been done in western countries and India but there is scarcity of study in children of Jharkhand state.

The present work is an attempt to identify and to assess the pattern and prevalence of behavioral problems in school children of Ranchi. Nowadays, because of rapid industrialization and urbanization majority of young couples are employed and live in unitary set up, so unavoidably they get less time to look after their children. Under these circumstances emotional and behavioral problems in their young children are on the rise. Almost all studies report a higher prevalence role of problem behavior in boys (Banik, 1972; Rubin & Balow, 1978). Prevalence of conduct disorder have been reported to be higher among boys while anxiety, withdrawn were found to be more common among girls. There is a dearth of researches on problem behavior as seen in general population.

Objective

- The main objective of the present research was to assess the incidence and nature of problem behavior in the adolescents i.e. the age group of 12 to 14 years. It was planned to examine the impact of gender and socio-economic status on the behavioural problems of adolescents.

Hypotheses

- i) Behavioral problems would be prevalent in school going children of Ranchi.
- ii) There would be significant difference in prevalent and nature of behavioral problems according to gender and socio-economic status.

METHOD

Sample

Twelve to Fourteen years old children studying in VI to VII class belonging to high (monthly income of the family ranges from 1 lac - 1 lac 50 thousand) and low (ten thousand - twenty thousand monthly) economic group, comprised the sample for the present study. Out of 858 children 520 are male and 338 are female selected by purposive sampling technique from nine high schools of Ranchi. Respondents of this study were the class teachers of the respective classes of each school.

Tools

- (i) *Socio-demographic data sheet* was prepared to collect socio-demographic details of the participants. It included details such as name, age, class, families income etc.
- (ii) *Revised behavior problems checklist*: Revised behavior problem checklist developed by Herbert Quay and Donald R Peterson (1980) used to assess problem behavior observed in young children. There are 89 items that are rated on 3 - point scale with responses; not a problem, mild problem and severe problem. The items of the checklist are scored on 6 scales which are leveled as conduct disorder, socialized aggression, attention problem - immaturity, anxiety withdrawal, psychotic behavior. Psychotic behavior and Motor tension excess. The test-retest reliability of RBPC across a two month interval ranged from 0.49 to 0.83.

Procedure

Permission to conduct the study was taken from the school authorities and informed consent was taken from the parents/guardians of these children. A group meeting was conducted with the teachers of the children. Thereafter teachers of selected children were administered revised behavior problem checklist. The answered checklist were collected and scored as per manual.

RESULTS AND DISCUSSION

The data were analyzed with the help of SPSS, version-10. Percentage and Chi-square test was used for group comparisons. Table I describes the socio-demographic profiles of the study population.

TABLE 1: Socio-demographic profile of Study Population

Variables		Frequency	Percentage
Gender	Boys	320	61
	Girls	338	39
Age	12 Years	152	17.72
	13 Years	520	60.61
	14 Years	186	21.67
Religion	Hindu	580	67
	Muslim	140	16.32
	Christian	99	11.54
	Sikh	39	4.55
Background	Urban	800	93.24
	Rural	58	6.76
Family Type	Nuclear	662	77.16
	Joint	196	22.84

Prevalence and Patterns of Problem Behavior

Family Income	High <100,000	640	74.59
	Low 10,000>	218	25.41
Per month	High	246	28.67
	Medium	510	59.44
Education	Low	102	11.89
	Upper	398	46.39
Caste	Lower	460	53.61

In the present investigation among 858, 520 children (61%) were male and 338 (39%) were female. Most of the children were from higher income group, belong to Hindu religion and from urban back ground (93.4%). It was observed that most of the children having behavioral problems were in the age group of thirteen. Maximum children were from lower casts (53.61%) with average parental education (59.39%). Most of the children were Hindu (67%) and belonging to nuclear family (77.16%).

TABLE 2: Prevalence and Nature of Problem behavior

Problems	No Problem		Problem	
	N	%	N	%
Conduct Disorder	820	95.57	38	4.43
Socialized Aggression	823	95.92	35	4.07
Attention Problem	763	88.93	95	11.07
Anxiety Withdrawal	650	75.76	208	24.24
Psychotic Behavior	825	96.15	33	3.85
Motor Tension - Excess	800	93.24	58	6.76

Table 2 shows that prevalence of various disorders ranged between 3.85 to 24.24%. Highest prevalence was found for Anxiety withdrawal 24.24% followed by Attention Problem (11.07%), Motor Tension - Excess (6.76%), Conduct Disorder (4.435), Socialized Aggression (4.075) and Psychotic Behavior (3.855). Anxiety withdrawal (24.24%) was most prevalent disorder in this study. Similar result was also reported by Tirkey and Jahan (2007), and Li et al (2001) Psychotic behavior was found less in comparison to other disorders (3.85).

Table 3: Severity of Problem behavior

Problems	No Problem		Mild Problem		Severe Problem	
	N	%	N	%	N	%
Conduct Disorder	820	95.57	25	2.91	13	1.52
Socialized Aggression	823	95.92	22	2.56	13	1.52
Attention Problem	763	88.93	88	10.25	07	0.81
Anxiety Withdrawal	650	75.76	200	23.31	08	0.98
Psychotic Behavior	825	96.15	32	3.72	01	0.12
Motor Tension Excess	800	93.24	52	6.06	06	0.69

Findings revealed that Conduct Disorder and Socialized Aggression were found most severe (1.52%) problem among adolescents. Similar result was reported by Tirky and Jahan (2007), Rai and Mallik, 1993. In mild level Anxiety Withdrawal (23.33%) was found to be most common followed by Attention Problem (10.25%) and Motor Tension - Excess (6.06%).

Table 4: Prevalence of specific behavior problems among male and female children

Problems	Gender	No Problem		Mild Problem		Severe Problem	
		N	%	N	%	N	%
Conduct Disorder	Male	500	96.15	15	2.88	5	0.96
	Female	320	94.67	10	2.95	8	2.37
Socialized Aggression	Male	498	95.77	12	2.30	10	1.92
	Female	325	96.15	10	2.95	3	0.89
Attention Problem	Male	443	85.19	70	13.40	7	1.35
	Female	320	94.67	18	5.32	0	0
Anxiety Withdrawal	Male	468	90.00	50	9.62	2	0.38
	Female	182	53.85	150	44.38	6	1.77
Psychotic Behavior	Male	512	98.56	08	1.54	0	0
	Female	313	82.60	24	7.10	1	0.19
Motor Tension - Excess	Male	460	88.46	40	7.69	20	3.85
	Female	320	94.67	12	3.55	6	1.78

Result shows that Motor Tension - Excess (3.85%), Socialized Aggression (1.92%) and Attention Problem (1.35%) were found most in male adolescents in severe level, whereas Conduct Disorder (2.37%) and Anxiety Withdrawal (1.78%) were found most in female adolescent in severe level. Severe problem was most prevalent in males than in females in the area of Socialized Aggression, Attention Problem and Motor Tension - Excess. In the mild level problem behavior was present more in males in Attention Problem (13.40%) and Motor Tension - Excess (7.69%). Anxiety Withdrawal was found more in females (44.38%) and Attention Problem was found more in males (13.40%). The difference between both sexes was found to be statistically significant ($X^2 = 786.55$; $P < .001$). Review of available research on problem behavior in children report a high prevalence rate of behavior disorder in boys (Rubin & Balow, 1978), Kumpulainen et al. (1999), Sood and Misra (1999), Dutta (2009) and Luk et.al 1991), Ahmed et al. (2007), Mehra (1960).

Table 5: Prevalence of specific behavior problems among adolescents of High and Low Socio-economic back ground.

Problems	SES	No Problem		Mild Problem		Severe Problem	
		N	%	N	%	N	%
Conduct Disorder	HSES	418	97.44	8	1.86	3	0.70
	LSES	402	93.71	17	3.96	10	2.33
Socialized Aggression	HSES	423	98.60	4	0.93	2	0.47
	LSES	400	93.24	18	4.20	11	2.56
Attention Problem	HSES	410	95.57	16	3.73	3	0.70
	LSES	353	82.28	72	16.78	4	0.94
Anxiety Withdrawal	HSES	300	69.93	128	29.84	1	0.23
	LSES	350	81.59	72	16.78	7	1.63
Psychotic Behavior	HSES	415	96.74	14	3.26	0	0
	LSES	410	95.57	18	4.20	1	0.23
Motor Tension -Excess	HSES	402	93.71	21	4.26	6	1.63
	LSES	398	92.77	31	7.45	0	0

$\chi^2 = 505.59$, $df = 22$. 001 Level

HSES:- High Socio-economic status,

LSES:- Low Socio-economic status.

Table -5 is showing prevalence and severity of specific disorder in adolescents of both high and low socio-economic back ground. Result shows that Motor Tension - Excess was more in adolescents of high socio-economic class in severe level. In mild level anxiety withdrawal was more in high socio-economic status group. Low socio-economic group of adolescents scored more in all disorders except for Motor Tension - Excess in comparison to high socio-economic status group. The calculated chi-square value was found to be 505.59 which showed significant association between problem behavior and socio-economic status.

Thus, it may be concluded that socio-economic status of the family has a major influence on the behavioural problems of child because it determines the level of comfort, parental care, facilities of a child which further contributes to his emotional status. Children from LSES families feel unloved rejected, disliked at home. Family problems are significantly higher in lower class children than HSES children which can be attributed to their lack of education, poor economic condition, poor health and quality of life. In the absence of proper facilities they get frustrated and ultimately become aggressive and suffers from anxiety, depression and exhibit different types of behavior problem.

Most of the studies done previously reported that physical environment and family income were the most significant predictors for problem behavior in girls (Sood & Mishra, 1999). Research studies reported that children from Lower SES have increased vulnerability to behavior disorder (Mehta 1989). Caste and SES have been shown to be related with problem behavior in Children. Higher

prevalence of the problems in lower SES adolescents also observed by Anita, Gaur, Vohra, Subodh and Khurana (2007).

CONCLUSIONS

- 1) Prevalence of behavioral problems in adolescents were found to be 9.07%. Anxiety withdrawal was the most common problem observed (24.12%) in these children followed by attention problem (23.31%).
- 2) Prevalence was more in female children (12.23%) than in male children (7.66%).
- 3) Behavioral problems were found to be more prevalent in children belonging to low Socio-economic status (10.14%) than high Socio-economic status (8%).

Implication

Result of this study may facilitate the identification of children at risk for developing problem behavior, So that more effective prevention and therapeutic programme could be evolved.

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WHAT MAKES ELDERLY HEALTHY? AN EMPIRICAL INQUIRY INTO PSYCHO-SOCIAL DYNAMICS

Shyodan Singh* and D. Chao**

ABSTRACT

Health status of the elderly can be considered a significant concern in the worldwide agenda. However, there is paucity of the knowledge base about the psycho-social dynamics which determines the health status. Against this backdrop this study examined the role of social support, purpose in life, attitude toward death and leisure activities as key elements of psycho-social dynamics in determining health in a sample of elderly in Delhi, India (n=200). The results indicated that purpose in life, social support and leisure activities contributed to the enhancement of the health of elderly. The study also revealed that marital status, living arrangement and chronological age also played an important role. The findings were corroborated by an in-depth study of a small set of qualitative data that underlined that positive attitude towards death along with purpose in life; social support and leisure activities helped in maintaining health. Taken together the findings implicate that interventions using social support, leisure activities and attitudes need to be included for augmenting the health status of the elderly.

Keywords: Social support, Leisure activities, purpose in life, attitude towards death, health, elderly.

Since time immemorial societies have been trying to evolve preparatory systems to cope with challenges in the life span. The Indian perspective of four ashrams namely Brahmacharya, Grisath, Vanprasth and Sanyas represents one such way to realize successful ageing. The first Ashram was preparatory. The second was consummatory. The third was of gradual withdrawal and fourth involved renunciation. It was clear that the ideal life was conceived as one in

* Assistant Professor, Department of Psychology, Zakir Husain Delhi College, University of Delhi, New Delhi-110-002

** Assistant Professor, Department of Psychology, Zakir Husain Delhi College, University of Delhi, New Delhi-110-002

which second half was for disengagement. While such ideas were not accepted in totality in practice, it did inform an overall view of life.

The purpose of the present study is to investigate the key socio-psychodynamics involved in health of the elderly as in the recent years, the scenario has drastically changed. People have gradually developed a new orientation in which late adulthood and old age do not necessarily require one to disengage. Today in many jobs the age is no bar and in many jobs the official age of retirement has become 65 years. This makes the meaning of 'elderly' quite different. Therefore, there is a need to re-examine what it means to be an aged person. It may be noted that individual and group level variations do exist in successful ageing because people vary in terms of social, psychological and physical resources and support available to them. Keeping in view the changing scenario and the need to promote quality of life of the aged, it is important to understand the various modes in which people define and strive to experience successful ageing. The exploration of successful ageing and its psychosocial correlates would be helpful in planning suitable interventions and developing effective social policy. Successful ageing is a multidimensional phenomenon involving psychological, physical, social, and economical dimensions. An individual's status along these dimensions determines the well-being of the elderly.

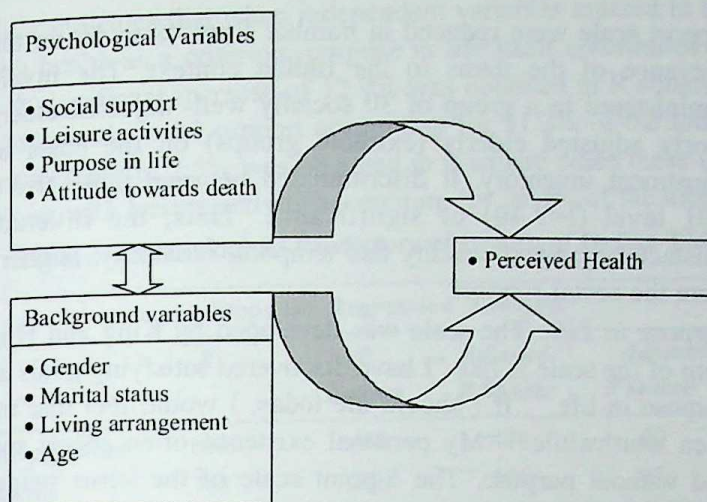
In traditional Indian family sons are supposed to take care of their parents. However, with the change in situation the elderly are now being treated in diverse ways. Many of them are put in a discarded corner of the house, or sent to old age homes. The loss of spouse often suffered by them leads to the feelings of emotional insecurity, and negative immunologic effects (Bartrop et al., 1977). Sandhu and Bakshi (2002) point out that elderly experience increasing degree of loneliness and alienation. They are sadder and depressed in the materialistic world and feel insecure. They also show increased sensitivity to infectious diseases and cancer, decreased antibody production to non-self antigens, and increased levels of auto-antibodies, defective NK activity, and decreased T-lymphocyte proliferation (Miller & Osoba, 1967).

While life expectancy has increased, poverty and breaking up of joint family system pose a threat to the care of aged persons. The forces of modernization, urbanization, social mobility leading to erosion of traditional values have also contributed to it. The image of ageing has always been overshadowed by negative connotations which arouse a fear of growing old. With no exception to India, demographic analyses reveal that the aged population constitutes a significant subgroup within the population. In 1961, the sixty plus population was around 25 million. Three decades later in 1981, it was a little over 43 million, a further decade later in 1991, this had increased to 54.7 million and for 2001, it was projected to be nearly 76 million (medium projection). Therefore, elderly are becoming one of the important segments of the population pyramid (Bose, 1988). In spite of

the large population with tremendous impact on the nation, research on the aged in India is insignificant (Easwaramoorthy & Chadha, 1997). Very few studies have examined on the needs and the problems of the elderly in various settings and groups (Bose & Gangrade, 1988; Desai, 1988). A cultural perspective is needed to explore the role of social variables involved in differential life changes (e.g., life expectancies, health status, mental health, etc.) and differential personal resources or prestige (e.g., income, marital status) (Singh, Chao, & Rajoria, 2015).

The image of ageing has always been overshadowed by negative attitudinal and behavioural characteristics which arouse a fear of growing old. The fragmented and the unauthenticated scientific investigation of human development and review of literature indicate that not much attention has been paid to "old age" (Singh, Chao, & Rajoria, 2015). With no exception to India, demographic analyses reveal that the aged population in the world constitutes a significant subgroup within the population. They are becoming one of the important segments of the population pyramid (Bose, 1988). In spite of the large population with tremendous impact on the nation, research efforts on the aged in India are comparatively insignificant. Some decades ago, many are in the opinion that the Indian research efforts are yet to make this presence felt (Easwaramoorthy & Chadha, 1997). It is further observed that only scanty information is available about the situation of the elderly in different strata of the society. Very few studies have been done on the needs and the problems of the elderly related to comparison of rural and urban settings, widowed and widowers, and even about the relatively better off section of the society (Desai, 1988). Efforts are required to invest more as the existing works are not adequate enough to identify and to determine their real picture of the aged. Many researches (e.g., Bose & Gangrade, 1988) observed that there is an urgency to evaluate the needs of the aged for comprehensive investigation of the elderly people in India.

The present study includes the indicators of health such as purpose in life, social support, leisure activities, attitude towards death, and background variables like marital status, living arrangement, and age. The assumptions and the structure of the present study can be summarized as under in figure-1.

*Figure 1: Indicators of Health*

METHOD

Sample

The total sample of the study consists 200 elderly persons who are residing in various colonies and zones of Delhi. The sample includes 100 males and 100 female elderly from different age groups. The sample was selected on the basis of non-probability incidental sampling technique, i.e., collecting data from the first available individual of the population.

Measures

Information Schedule: The information schedule would be prepared by the investigators to collect information about the respondents' i.e., age, education, marital status, living arrangements, number of children's, occupation and pension.

1. *Self-Rated Health* devised by Jamuna & Ramamurti in 1990. The scale consists of three statements relating to perception of health. The individual has to rate his or her health on a five point scale, greater the score better the ratings on health. The reliability of the scale is 0.87.
2. *Leisure Time Activities:* The checklist prepared by Van Willigen and Chadha (1989) consists of 24 items comprising 22 activities. These activities are classified under the following four categories: cultural, physical, social and solitary. High score indicates participation in more leisure activities.
3. *Social Support Network Schedule:* Cohen and Hoberman (1983) devised this schedule which consisted of 48 items with four sub-scales, each having twelve items. The sub-scales deal with questions about family, friends, neighbors and the peer group of the individual and about his relationship with each group. The reliability (test-retest) was calculated and found to be 0.78 (Pearson's r). The items of the original social

support scale were reduced in number from 48 to 20 on the basis of relevance of the items to the Indian context. The inventory was administered to a group of 30 socially well-adjusted elderly and 30 poorly adjusted elderly (extreme groups) on the basis of another adjustment inventory. It discriminated between these two groups at 0.01 level ($t=9.40$) of significance. Thus, the inventory has a satisfactory context validity and temporal reliability. Higher the score more the social support.

4. *Purpose in Life*: The scale was developed by King and Hunt (1975). Item of the scale is like "I have discovered satisfying goals and a clear purpose in life." "If I should die today, I would feel that my life has been worthwhile." "My personal existence often seems meaningless and without purpose." The 5-point scale of the items ranged from 1 (not true of myself) to definitely true of myself). The scale has negatively worded item and positively worded items with an alpha-value of .65.
5. *Attitudes toward Death*: Fear of death, death avoidance, and approach acceptance of death would be measured by the Death Attitude Profile-Revised (Wong, Reker, & Gesser, 1994). Fear of death consisted of the average of seven items (e.g., "I have an intense fear of death." "Death is no doubt a grim experience.") with an alpha-value of 0.84; death avoidance was the mean of five items (e.g., "I avoid death thoughts at all costs." "I always try not to think about death.") with an alpha of 0.85; and approach acceptance of death was the average of 10 items (e.g., "I believe that I will be in heaven after I die." "I look forward to life after death.") with an alpha of 0.97. All items were assessed on 5-point scales ranging from 1 (strongly disagree) through 5 (strongly agree).

RESULTS AND DISCUSSION

The main objective of the present study is to examine the role of social support, purpose in life, attitude toward death and leisure activities as key elements of psycho-social dynamics in determining health in a sample of elderly in Delhi, India ($n=200$). Therefore, stepwise regression analysis was applied.

Table 1: Psychological Predictors of Health of Indian Elderly

Predictors	Stepwise Regression Analysis				Beta Coefficients
	R	R Square	Adjusted R Square	Adjusted R square	
Purpose in life (positive)	.434	.188	.183	.00	.43
Social support	.567	.321	.312	.129	.36
Leisure activities	.614	.377	.364	.025	.23

Table 1 indicates that when independent variables entered in the regression model with health as a criterion, purpose in life itself contributed 18.3% of the variance. A significant increase of 12.9% was obtained in R square when it was entered along with social support accounting for 31.2% of the total variance. A significant increase of 2.5% was obtained in R square when these variables were entered along with leisure activity accounting for 36.4% of the total variance.

Table 2: Psychological Predictors of Health of Indian Elderly

Model	Stepwise Regression Analysis				
	R	R Square	Adjusted R Square	Adjusted R square	Beta Coefficients
Living Arrangement	.698	.488	.484	.00	-.69
Marital status	.748	.560	.554	.07	-.29

Table 2 indicates that when demographic variables entered in the regression model with health as a criterion, living arrangement itself contributed 48.4% of the variance. A significant increase of 7% was obtained in R square when it was entered along with marital status accounting for 55.4% of the total variance.

Purpose in life is found to be an important factor to determine the health of the elderly. The same was found to be predictor of health (Table:1). The findings of study support the findings of Ardel (2003) who found that purpose in life was a predictor of health of the elderly. These findings indicate that having a positive meaning and purpose in life will not only add years to one's life, but also add life to one's years. Without a clear sense of meaning and purpose in the face of physical decline, longevity may prove to be an unbearable burden. People need to develop a positive attitude towards life in order to maintain life satisfaction in the midst of losses and illness. Therefore, a sense of meaning and purpose in life appears to be particularly important during the later years of life when people are faced with inevitable social and physical losses and the approach of death. Wong (2000) suggests that the challenge of successful aging is to discover positive meanings of life and death even when one's physical health is failing. We need to address the needs of the frail, the disabled, and the chronically ill; we should not view them as unsuccessful agers. We need to look deeper and discover what enables one to triumph over prolonged illness and disability. Yes, the secret to successful aging for the frail and the dying lies in discovering meaning of life.

The present study indicates that social support plays an important role in maintaining the health of the elderly (Table: 1). Broadly there are two hypotheses relating the effect of social support to health and well-being: one that it enhances well-being directly and the other is that it acts as a buffer against stressful experiences which in turn affects health. This effect hypothesis works in two ways: first is the impact on self-esteem, and the second effect is that it provides

security in the event of distressing circumstances. The results of the present study show that social support plays an important role in maintaining health of elderly (Table: 1) because supporting relationships like having close friends and involvement in a supportive network contributes to the elderly sense of security, positive evaluations of life experiences, personal worth and competence, and this in turn enhances the health and well-being of elderly. Thus, social support is important for the well-being of retirees, as it gives one a feeling of being loved, cared for, esteemed, valued and belonging to a network of communication and mutual belongingness (Singh, 2005). In a study Sharma (1995) found that social support was positively and significantly correlated with well-being of elderly. It also enhances the prospects for recovery among people who are already ill (Wallston, et. al., 1983).

Leisure activities are also predictor of health of elderly (Table:1). Jonsson (1993), Sharma (1995), Sinha and Singh (1997), Amy, et. al. (1998), and Benymini, et.al (2000) point out that engaging in activities leads to better well-being. These findings reminded that leisure participation, by itself, is sufficient to foster well-being. The satisfactions and meanings people derived from their leisure participation also have important implications for well-being. Utilizing this time and encouraging elderly to participate in activities like evening and morning walking and other activities may benefit their well-being.

Living arrangement found to be a significant predictor of health of the elderly (Table: 2). Undoubtedly, there were unbreakably bonds with family in the olden Indian society. The traditional nature of Indian family, where sons are supposed to take care of their parents, the bond of relationship between young and old generation is unbreakable (Singh, Chao, & Rajoria, 2015). The constitution of India also has made a provision that the state shall provide for public assistance in the case of old age. Article 41 of the constitution of India reads as under: "The state shall, within limits of its economic capacity and development make effective provision for securing the right to work, education and to public assistance in case of unemployment, old age, sickness and disablement, and in other cases of undeserved want." But young children are no doubt drifting away but middle aged people are still not ready to shed their elderly from their lives and bear them willingly or unwillingly. Many of them may be given discarded corner of the house, but are not sent to old age homes. Although many elderly widowers are finding their ways in old age homes, elderly women do not shift. This is mainly because of feeling or emotion insecurity, emotion bond with children and because she may still be useful to daughter in law in rearing children and doing household chores (Singh, Chao, & Rajoria, 2015).

Results also indicated (Table:2) that marital status of the elderly found to have influence upon the health of the elderly. The results of study are in line with Crandall (1980) who found that individuals who live with their spouse are

happier and have better health. Being married and living with spouse is an important source of support for elderly which is linked to better health. Discontinuity in marital status, separated seems to have disruptive consequences and negative effects on the health of elderly. Holmes and Rahe (1976), Thompson (1984) found that the death of a spouse is a major life stressor which affects health of the elderly. Jamuna and Ramamurti (1990) also found that widows were poorly adjusted as compared to non-widowed elderly. Following widowhood there is a usually a sudden loss of financial support and a consequent lowering of the standard of living. Widowhood has been conceptualized as a negative evaluated social category where the individual loses the central source of identity, financial support and social relationship, thus widowhood is a role-less role (Heltz, 1986). Widowhood with few or no role involvements leads to poor adjustment.

These findings are in line with the findings of Pfeiffer (1979); Young, (1982); Essex, (1985); and Mullins, (1989) who had found a noticeable decrease in mental health among the widowed. Widowed receive little or no help in restructuring their lives after the death of their spouse and their poor mental health is manifested in the form of excessive drinking, excessive smoking, neglect of health, etc., widowed person experiences lower levels of well-being largely because they tend to be older, in poorer health, and less active in social life than their living with spouse counterparts. In the case of widowed women low economic resources is also a key factor of poor health, however, there was no evidence of a consistent pattern of greater reduction in levels of participation in widowhood for men (Arens, 1982). Evidence also indicates that becoming widowhood is more traumatic than remaining single (Gubrium, 1974).

Implications

The results of study suggest that participate in leisure activities and get social support could reduce health related problems. Further, encouraging them to have purpose and meaning in life, involve in leisure activities, making a realistic appraisal of themselves and their problems and help them to get rid of their irrational beliefs could enhance the health and well-being of elderly. The younger generation can also play a vital role in supporting and encouraging them to remain alive and have a purpose and meaning in life. The present study would provide to significantly contribute to suggest and guide the Government Welfare agencies in framing welfare policies and the future intervention programmes. It would also likely to help medical experts, mental health professionals, and other professionals, care givers who are concerned for the welfare of the aged, by highlighting, depicting, and portraying the real picture of the elderly position in the sphere of physical health, psychological state, social environment, economic well-being, spiritual well-being and others.

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ACROSS GENERATION STUDY OF SUBJECTIVE WELL-BEING

Pooja, Deepti Hooda** and NovRattan Sharma****

ABSTRACT

Subjective Wellbeing is not a unitary construct, rather it comprises of multiple components. Subjective wellbeing focuses on greater life satisfaction, more positive affect and lesser negative affect. Subjective Wellbeing takes into account hedonic concept of wellbeing. Many visible and significant cultural changes have taken in Indian society over the last two decades, as a result of the technological advancements, globalization and modernization. Due to which there is rapid economic growth that has resulted in cultural holocaust bringing a dynamic change in lifestyle and belief system. There is a dearth of research that takes in account the effect of generation on Subjective Wellbeing. Generational differences are the subject of much popular speculation but relatively little substantive research. There are differences of opinions, beliefs, and other social and cultural norms that exist between older and younger age groups. These differences are often widened by technological advancements. Thus, to fill in the gap in knowledge, the present study is designed to assess and compare Subjective wellbeing across three generations. The sample consists of 300 respondents, 100 in each group i.e. Children, Parents and Grandparents, from various districts of Haryana especially Rohtak and nearby areas. Respondents for the three generation groups were taken from the same family i.e. (three subsequent generations) in order to reduce within group variance. The Satisfaction with Life Scale and Positive and Negative affect schedule were used to assess Subjective wellbeing. The obtained data were subjected to statistical analysis using

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- * Research Scholar, Dept. of Psychology, Maharshi Dayanand University, Rohtak, Haryana.
- ** Assistant Professor, Dept. of Psychology, Maharshi Dayanand University, Rohtak, Haryana. (Corresponding Author) email: deepti.hooda17@gmail.com
- *** Professor, Dept. of Psychology, Maharshi Dayanand University, Rohtak

SPSS software, One way ANOVA (Repeated Measure) was applied to the data. The results and implications of the study are discussed in detail in the paper.

Keywords: Satisfaction with life, Positive affect, Negative affect, and Generational differences

Well-being is a general term for the condition of an individual which may includes one's physical, social, psychological, medical, spiritual and economic state. Thomas (2009) states that wellbeing "is intangible, difficult to define and even harder to measure". There are two perspectives of well-being eudaimonic and hedonic. According to Ryan and Deci (2001), these perspectives are relatively distinct but overlapping. The eudaimonic perspective of wellbeing is typically operationalized as psychological wellbeing. According to Aristotle, the "eudaimonic perspective", is self realization, meaning of expression and the fulfilment of inner potentials. Thus, eudaimonic wellbeing can be enhanced through developing one's potentials and achieving the goals. Waterman (1993) argued that eudaimonic happiness results from experience of personal expressiveness. And such experience occurs when one is fully engaged in life activities that fit and express deeply held values and sense of who one is. The hedonic well being is typically operationalized as Subjective Wellbeing (SWB) and encompasses a cognitive and affective component (Diener & Lucas, 1999). The hedonic approach focuses on the activities that produce good feelings such as warm glow, happiness, pleasure, or enjoyment. According to Diener (1984), hedonic view is expressed in the study of SWB.

For a lay person, Subjective wellbeing is a scientific term for happiness (Seligman & Csikzentnigholy, 2000). From past few years psychologist have started studying Subjective wellbeing in a scientific and systematic way. In past decades, psychology was a discipline which focused mainly on problems i.e. anxiety, depression and other maladies. The psychologists have not been much concerned about the positive aspects of human experience. Seligman started the Positive Psychology movement, which has shifted the focus of psychological research and practice on helping people to have a more meaningful, happier and satisfied life by experiencing greater subjective wellbeing. Synder and Lopez (2002) defined "Subjective wellbeing as a person's cognitive and affective evaluations of life. These evaluations include the emotional reactions to events as well as cognitive judgments of satisfaction and fulfilment". However, Vleioras and Bosma (2005) define Subjective wellbeing "as feeling well, which is highly parallel to the characteristics of a healthy personality". Subjective wellbeing is a combination of "positive affect (in the absence of negative affect and general life satisfaction," according to Diener, (1984, 2000); Diener, Lucas & Oishi (2002). Thus, Subjective wellbeing includes three primary components i.e. Life satisfaction, Positive affect and Negative affect.

Life satisfaction is a very important and essential part of Subjective wellbeing because it always best reflects the philosophical notion of the good and happy life (Veenhoven, 1993). 'Satisfaction' is a Latin word that means to make or do enough. Satisfaction with one's life implies a contentment with or acceptance of one's life circumstances or the fulfilment of one's wants and needs for one's life as a whole. Satisfaction with life can be categorized by satisfaction with current life, past, future and others views to one's life and the desire to change their life. Thus, Life satisfaction can be defined as the overall cognitive evaluation of individual's quality of life or cognitive evaluation of important and specific domains like marriage, school, work and other areas of life (Diener, 1994; Myers & Diener, 1995). Life Satisfaction judgements are not absolute but rather based on individual's self evaluation of salient information. Criteria and Information used for judging life satisfaction may vary from person to person. Life satisfaction can be change from time to time (Synder & Lopez 2002). While, Oishi, Diener, Suh and Lucas (1999) found that life satisfaction remains constant across time.

The emotional component of Subjective wellbeing can be described with the concept of Positive and Negative affect. Historically, the positive affects have received little attention over the last century. Diener and Emmons (1985) considered positive and negative affects as highly different but weakly associated. Frederickson's broaden and build model hypothesize that with positive emotions individual's awareness can be increased and it makes their learning strong to create intellectual and emotional resources for future. The positive emotions also help them to increase the available alternatives. Frederickson and Branigan, (2005) also stated that the benefit of positive emotion is that it may work as an antidotes for negative emotions. Positive affectivity is the extent to which individual express enthusiasm, pleasure and contentment; and the co occurrence of positive emotions i.e. interest, joy, alertness, confidence and excitement.

Positive affect includes pleasant moods and emotions such as joy and affection. Positive or pleasant emotions are part of subjective well-being as they are a person's reactions to events that indicate that his/her life is proceeding in a desirable way. Positive emotions can be categorised into three levels of arousal (i) low arousal, which includes positive emotions like contentment (ii) medium arousal e. g. Pleasure and (iii) high arousal state includes positive emotions like euphoria. Positive emotions can also be classified on the basis of their direction of positive reactions, positive reaction to activities like interest and engagement and general positive moods like joy. Negative affect includes moods and emotions that are unpleasant and represents negative responses people experience in reaction to their lives, health, events and circumstances. Major kinds of negative affect or unpleasant emotions include anger, sadness, anxiety and worry, stress, frustration, guilt and shame and envy. Negative states, such as loneliness or helplessness are also important indicators of ill-being. At times some negative

emotions are unavoidable part of life and may be necessary for effective functioning, but frequent and prolonged negative emotions indicate that a person's life is not proceeding happily.

People vary in their experience of Subjective wellbeing, from agony to ecstasy. Some individuals have higher Subjective wellbeing while their living situations are adverse and others have lower Subjective wellbeing despite having all the good things of life like wealth, education and good health and have full advantages of all these things (Seligman & Csikszentmihalyi, 2000). But one of the most fundamental problems in research on well-being is uncertainly about which variables are the causes and which are the consequences. Identifying factors that contribute to well-being is not a simple matter (Diener & Lucas, 1999). However, most of variables described as causes have only been shown to be correlates of well-being and might conceivable be consequences or perhaps both causes and consequences. Wilson (1967) also studied the correlates of avowed happiness and found that happiest people are young, healthy, well educated and have modest aspiration of either sex and of a wide range of intelligence.

Technological advancement, globalization & modernization have brought significant culture changes in Indian society over the last two decades. The rapid economic growth has resulted in cultural holocaust and has changed our society to a great extent by changing the value and belief system, lifestyle, health and wellbeing. These incredible technological and economic changes has lead to a great deal of speculations about Generational differences but there is a dearth of systematic empirical research in this area. Despite the lack of consistency in nomenclature and chronology of different generations, most researchers agree that a great deal of variance exists among the various characteristics of different generations. This makes inadvisable for a researcher to assume that people born in 1940s think, believe, act and live life in the same way as persons born in 1970s or individuals born in 2000s have different economic and social conditions, technological advances, and other societal changes than their earlier generations

There is a paucity of research that has taken into account the effect of generation on Subjective Wellbeing. Thus, to fill in the gap in knowledge, the present investigation is designed to study Subjective wellbeing across three generation.

METHOD

Sample

For the selection of sample purposive sampling method was used. Respondents for the three generations group were taken from the same family i.e. (three subsequent generations) in order to reduce within group variance. Initially children of schools of various districts of Haryana were contacted at their respective schools, and respondents who were residing with their parents

and grandparents were requested to participate in the study. All the respondents, Children (Boy/Girl, age range 11-17 years), Parents (father/mother, age range 30 to 50 years) and Grandparents (grandfather/grandmother, age range 60 to 90 years) who voluntarily agreed to participate in the study were selected. The total sample was 300, 100 in each generation group i.e. Children (generation 1), Parents (generation 2) and Grandparents (generation 3).

Tools

To assess Subjective wellbeing following measures were used

Satisfaction with Life Scale (SWLS): To assess satisfaction with life SWLS scale by Diener, Emmons, Larsen and Griffin (1985) was used. The five-item scale assesses subject's overall judgment about their life. The 5 items of the SWLS were selected from a pool of 48 items based on factor analysis. The items are to be rated on 7 point Likert type scale from strongly disagree to strongly agree. The minimum possible score on this scale is 5 and the maximum possible score is 35, where higher score indicates greater life satisfaction. Pavot and Diener (1993) have reported a range of Means for various groups of individuals e.g. undergraduates, health workers was 14.4 to 27.9. While the range of standard deviations was 4.4 to 9.0. Diener et al (1985) reported a 2-month test-retest correlation coefficient of 82 and an alpha coefficient of 87 for a sample of 176 undergraduates from the University of Illinois. Pavot, Diener, Colvin and Sandvik (1991), in a sample of 39 elderly individuals obtained an alpha coefficient of 83. The SWLS has been found to be positively and significantly associated with other measures of subjective well-being whereas, negatively associated with measures of psychopathology (Diener et al, 1985). This scale was translated in hindi using standard methodology of translation. Three bilingual experts who had good command on both languages (English and Hindi) translated the original questionnaire into Hindi. This forward translation was then translated back into English by three other language experts who were unaware of the original questionnaire. These forward and back translations were reviewed by two other language experts to produce the final Hindi version. After completing the translation process, the final Hindi version and the original version of Satisfaction with Life Scale were administered on 50 children. The test retest reliability was found 0.69 and validity was 0.75.

Positive and Negative affect Schedule (PANAS): PANAS is developed by Watson, Clark and Tellegen (1988). The schedule comprises of two mood scales, one measures positive affect and the other measures positive affect and the other measuring negative affect. It contains 20 items, each items is rated on a 5-point scale, ranging from 1 (very slightly or not at all) to 5 (extremely). Positive affect is assessed by 10 items (1, 3, 5, 9, 10, 12, 14, 16, 17 and 19) while Negative affect is also measured by 10 items (2, 4, 6, 7, 8, 11, 13, 15, 18 and 20). The scale gives two separate scores for Positive and Negative affect. This scale can be used to measure affect of the present moment, today, past few days, past

week, past few weeks, the last year and generally overall Affect. Watson et al. (1988) reported Cronbach's alpha coefficients for the various time reference periods ranging from 86 to 90 for the Positive Affect scale and 84 to 87 for the Negative Affect scale. For the general period, alpha was 88 for Positive Affect and 87 for Negative Affect. Test-retest correlations for an 8-week period ranged from 47 to 68 for Positive Affect, 39 to 71 for Negative Affect (for the time period. Positive Affect stability = 68, Negative Affect stability = 71). For the purpose of validity the scale was correlated with scores on measure of general distress and dysfunction, depression and state anxiety. This Schedule was also translated in hindi using same translation procedure as mentioned above. The test retest reliability was found 0.71 and validity was 0.74.

Procedure

To fulfill the purpose of the present investigation, all the measures of Subjective well being were administered on all the respondents personally or in small groups, after obtaining informed consent and establishing the rapport with the subjects. After ensuring that the subject has understood the method, the selected questionnaires were administered to the children (generation 1) in the free period during school time and to their parents and grandparents during parents meet in school. The parents and grandparents who were unable to reach the school, on them test were administered in their homes. The scoring was done as per manual. After this, the data was analyzed using SPSS software.

RESULTS AND DISCUSSION

The main objective of the present study is to compare Subjective Wellbeing across three generations. Therefore, one way repeated measure and post- hoc analysis was applied on all the three sub dimensions of Subjective well being.

Satisfaction with Life

To compare the three generations on Satisfaction with Life, one way ANOVA (Repeated Measure) was applied. The obtained F value for families was found to be significant ($F=3.25, p<.01$), implicating that Satisfaction with Life differs across families, while the F values for generation was not significant ($F=1.49$), which means that Satisfaction with Life does not differ between three generations (children/ Parents/ Grandparent).

Table 1: Summary of One Way ANOVA (repeated measure) of Satisfaction with Life

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>
Between Families	6148.597	99	62.107	3.25**
Between Generation	100.84	2	50.42	1.49
Error	6699.15	198	33.83	

** $p<0.01$

Positive Affect

To compare Positive affect across three generations, One way ANOVA (Repeated Measure) was applied. The values of F for between families was found to be significant ($F=4.07, p<.01$). The result shows that Positive affect differs from family to family. Also the F values for generation was significant ($F=8.66, p<.01$), pointing out that Positive affect significantly differs across generations. As F values for between generation was found to be significant, a post hoc analysis (LSD) was applied to compare multiple mean groups.

Table 2: Summary of One Way ANOVA repeated measure of Positive affect.

Source of Variation	SS	df	MS	F
Between Families	9057.13	99	91.48	4.07**
Between Generation	646.02	2	323.01	8.66**
Error	7385.98	198	37.3	

** $p<0.01$

Table 3: LSD post- hoc analysis of mean differences on Positive affect between the three generation groups.

Generation Groups	Mean	Mean difference
Children (Generation 1)	37.18	2.31*
Parents (Generation 2)	34.87	
Children (Generation 1)	37.18	3.54*
Grand Parents (Generation 3)	33.64	
Parents (Generation 2)	34.87	1.23
Grand Parents (Generation 3)	33.64	

* $p<0.05$

The table no. 3, shows that on Positive affect the mean scores of Children (generation 1) was 37.18, Parents (generation 2) was 34.87 and Grandparents (generation 3) was 33.64. LSD post hoc analysis showed that Children (generation 1) differed significantly from Parents (generation 2) and Grandparents (generation 3). This means that Children express more Positive affect than their Parents and Grandparents. They perceive themselves more active, attentive, alert, excited, proud and determined. While no significant difference was found between parents and grandparents generation groups.

Table 4: Trend analysis of Positive affect scores for the three generation groups.

Source of Variation	Ss	df	MS	F
Liner	626.58	1	626.58	14.69**

** $p<0.01$

Table no. 4 points out significant linear trend in Positive affect between generations. This means experience of Positive affect increases from Grandparents (generation 3) to Parents (generation 2) then to Children (generation 1), which implies that Children experience more Positive affect than their parents and grandparents (as depicted in figure no. 1).

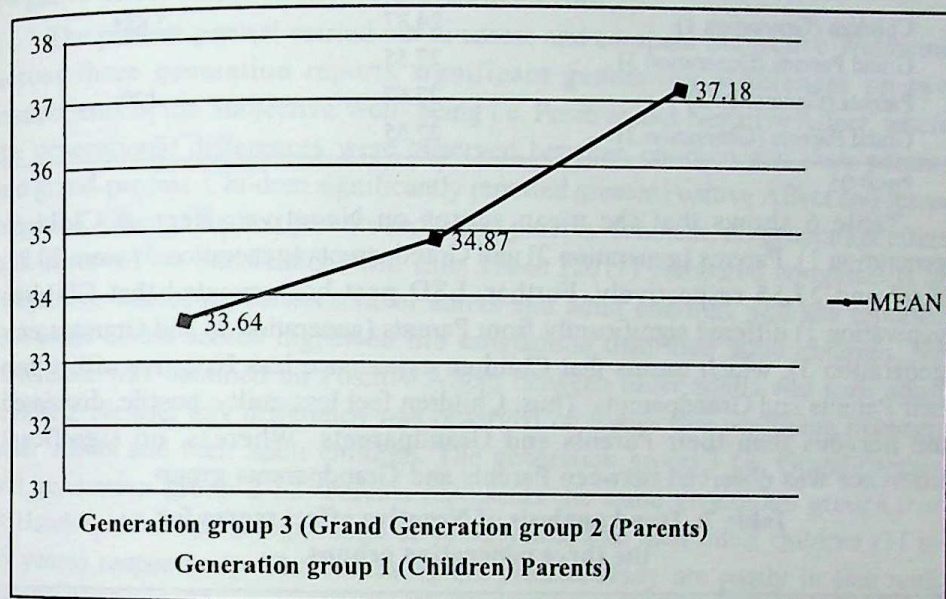


Figure 1: Graphical representation of trend in mean Positive affect scores for the three generation groups.

Negative Affect

One way ANOVA (Repeated Measure) was applied to compare Negative affect across three generations. The analysis indicated that the F value for between families was found to be significant ($F=1.80, p<.01$), that means Negative affect differs from family to family. The obtained F value for between generation was also significant ($F=4.65, p<.01$). It indicates that Negative affect significantly differs between the three generations. As F values for between generation was found to be significant, a post hoc analysis (LSD) was applied for multiple mean groups.

Table 5: Summary of One Way ANOVA repeated measure of Negative affect.

Source of Variation	SS	df	MS	F
Between Families	11728.730	99	118.472	1.80**
Between Generation	501.23	2	250.61	4.65**
Error	10663.44	198	53.86	

** $p<0.01$

Table 6: LSD post- hoc analysis of mean differences on Negative affect between the three generations groups.

<i>Generation Groups</i>	<i>Mean</i>	<i>Mean difference</i>
Children (Generation 1)	24.87	-2.80*
Parents (Generation 2)	27.67	
Children (Generation 1)	24.87	-2.68*
Grand Parents (Generation 3)	27.55	
Parents (Generation 2)	27.67	.120
Grand Parents (Generation 3)	27.55	

* $p < 0.05$

Table 6 shows that the mean scores on Negative affect of Children (generation 1), Parents (generation 2) and Grandparents (generation 3) were 24.87, 27.67 and 27.55 respectively. Further, LSD post hoc revealed that Children (generation 1) differed significantly from Parents (generation 2) and Grandparents (generation 3), which means that Children experience less Negative affect than their Parents and Grandparents. Thus, Children feel less guilty, hostile, distressed and nervous than their Parents and Grandparents. Whereas, no significant difference was observed between Parents and Grandparents group

Table 7: Trend analysis of Negative affect scores for the three generation groups.

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>
Liner	359.120	1	359.120	5.273**

** $p < 0.01$

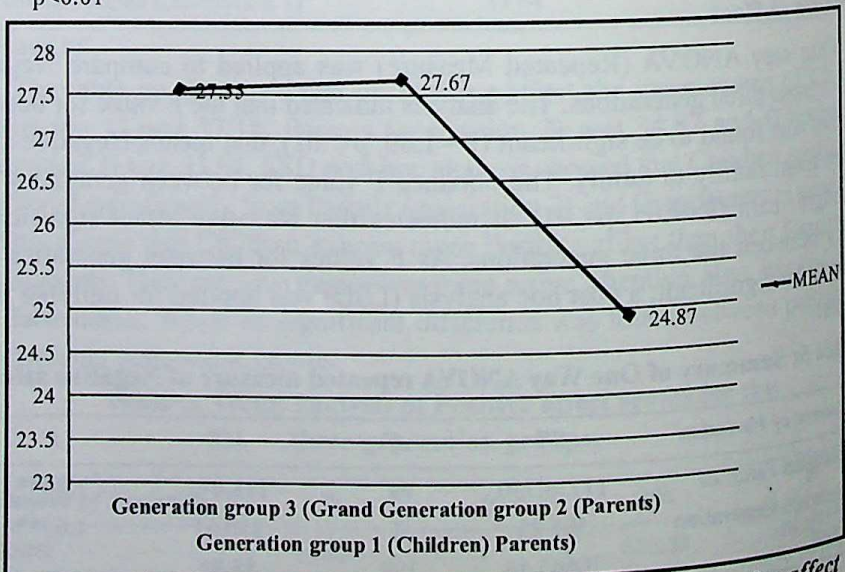


Figure 2: Graphical representation of trend in mean Negative affect scores for the three generation groups.

Table 7 indicates significant linear trend on Negative affect between generations. Figure no. 2 clearly shows that Negative affect increases from Grandparents (generation 3) to Parents (generation 2) but the increase was not found to be significant, while it decreases from Parents (generation 2) to Children (generation 1). Thus, trend analysis clearly shows that Children experience less Negative affect than the Parents and Grandparents.

The present perusal carried out to assess and compare Subjective Wellbeing across three generation reports significant generation differences on two components of the Subjective Well-being i.e. Positive and Negative Affect, where the generational differences were observed between children and their parents and grand-parents. Children significantly reported greater Positive Affect and lesser Negative Affect than their parents and grand-parents. Whereas, no generation effect was observed on Satisfaction with Life. Hsieh (2011) compared components of Subjective wellbeing between older adults and adult children, and has reported that older adults scored higher on life satisfaction than their adult children. No difference was obtained on Positive Affect between older adults and their adult children. Neither any difference was observed on Subjective wellbeing between older adults and their adult children. The generation group 3 i.e. Grand-parents and generation group 2 i.e. Parents represents the same generation groups that of Hsieh's older adults (age range 65 to 95 years) and their adult children (31 to 69 years) respectively. The results of the present study are partly in line with Hsieh's findings. The present investigation reports no generational difference in Life satisfaction, which are not in line with Hsieh's finding, who found higher Life satisfaction in older adults than their adult children. In regard to Positive Affect, findings of both the studies are in line, reporting no difference in Positive Affect between the two generations under study.

CONCLUSION

The present study provides insight into how Subjective wellbeing components (Satisfaction with life, Positive affect and Negative affect) differ across generations as well as across families. All the components of Subjective wellbeing were found to vary from family to family. Generation differences were observed on Positive affect and Negative affect and not on Satisfaction with life. These findings emphasize the need for designing intervention programs for promoting Subjective wellbeing according to the target generation. Moreover, the findings of the study highlight the importance of family-centered programs in promoting family wellbeing as well as wellbeing of each family member.

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BIG FIVE PERSONALITY FACTORS IN RELATION TO PSYCHOLOGICAL EMPOWERMENT OF FEMALE COLLEGE STUDENTS

S. Punithavathi and C. Balakrishnamurthy***

ABSTRACT

In the recent scenario, women play a pivotal role in personal and professional settings. Thus, the word women empowerment, has become at most significant. The present study attempts to study the pervasiveness of psychological empowerment of female college students in relation to their personality. The main aim of the study is to find the relationship between psychological empowerment: meaning, competence, self-determination and impact with personality traits: neuroticism, extroversion, openness, agreeableness, conscientiousness. A sample of 30 female college students is included from an Arts and science college in the age group of 18 to 20. The Psychological Empowerment Questionnaire and Big Five Personality are administrated to investigate the relationship between psychological empowerment and big five personality factors. The findings reveal that extraversion trait is significantly and positively related with all the dimension of psychological empowerment. Neuroticism trait is significantly and positively related with meaning and competence psychological empowerment. Openness is significantly and positively related with meaning and self-determination. Conscientiousness is significantly and positively related with meaning alone. At the same time, the agreeableness trait is not related with all the dimensions of psychological empowerment.

Keywords: Psychological Empowerment, Women empowerment; and Personality Factors.

Psychological empowerment has become new concept in Indian context and a very few work are present in the area of psychological empowerment and big

* Assistant Professor of Psychology, PSG College of Arts & Science, Coimbatore - 14.

** Assistant Professor of Psychology, PSG College of Arts & Science, Coimbatore - 14. 7598129505. cbalakrishnan@india.com

five personality factors. So there arised need to investigate relationship between big five personality factors and psychological empowerment among college going female students. The effect of personality traits and empowerment is of utmost importance as women's empowerment can be understood through physical, social, and psychological impact.

Psychological empowerment is an emerging field, which has a lot to know about in it. Each distinguished author defines it differently. The renowned Spreitzer (1997) defines it as a set of motivational cognition, shaped in an organizational environment or situation to his or her work role. Melhem, (2004) points out that empowerment is concerned with providing latitude, authority and discretion in task and context-related behaviors. Usually, psychological empowerment consists of four cognitions- a sense of meaning, competence, self-determination, and impact. A sense of meaning can be described as the value one places on work; it refers to the meaning or purpose of the fit between the needs of one's work role and one's values, belief and behaviours. Competence can be described as an individual's belief in his or her capabilities i.e. the skills and abilities necessary to successfully perform, performance- related activities. Self-determination can be described as the individual's belief that autonomy or control exists in the way in which tasks and activities are performed. Impact refers to the individual's perception that organizational outcomes can be influenced by their activities and that their contribution can be a difference.

Personality refers to a combination of characteristics that comprise the unique nature of a person as that person reacts and interacts with others (Schermerhorn et al, 2012). Agreeableness shows personal differences in being warm, kind, intimate and sympathetic in social interactions with other people which help avoiding interpersonal oppositions. Agreeable individual have harmonious interpersonal environment due to their desire to get along (Barrick, Stewart, & Piotrowski, 2002). Agreeable individual who are sympathetic, co-operative and trusting – are drawn toward quality social interactions and are better team players (Costa & McCrae, 1992). According to McCrae (1996) openness personality deals with intellectual activity, cultural sophistication, thoughtfulness, originality, imagination; need for variety and preference for cognitive. Further Costa & McCrae (1992) suggested that openness traits consist behavior that convey willingness and readiness to entertain and experience novelty, whether in interest, people, situation, values or ideas and sense of divergent and creative thinking. It was found that individuals who possess high openness personality are more likely to emphasize rules, regulations, order and conformity, more flexible and tend to understand other's point of views easier. Therefore, one would expect individual's with higher levels of openness personality to be associated with high level of psychological empowerment since they are able to adapt to a variety of environmental factors and stimuli. Conscientiousness is defined as reliability

(cautious, exactness and responsibility), volition (hard working and progression) and it has been considered as the most important feature in job performance.

METHOD

In the line of earlier section, the present study is designed to explore the psychological empowerment and personality trait of female college students.

Sample

The sample for the study includes 30 female college students in Coimbatore, Tamil Nadu. The sample was drawn from Arts and Science colleges situated in urban area, belonging to the age group of seventeen to twenty years.

Research Design

The present study adapts Descriptive – Correlative Research Design.

Tools

The following tools are used for the study:

1. *Psychological Empowerment scale* developed by Spreitzer (1997) was used to measure the psychological empowerment. It has four dimension namely meaning, competence, self-determination and impact.
2. *NEO Personality Inventory* developed by Costa & McCrae (1992) was used for assessing the personality factors. It measures the five dimension of personality namely neuroticism, extraversion, openness, agreeableness and conscientiousness.

RESULTS AND DISCUSSION

The present study was designed to explore the psychological empowerment and personality trait of female college students. Mean and Standard Deviation of all the components of Psychological Empowerment and Big Five Personality Factors were computed. Table 1 and Table 2 shows Mean and Standard Deviation of Female College Students on Psychological Empowerment and Big Five Personality Factors.

Table 1: Mean and Standard Deviation of Female College Students on Psychological Empowerment (N = 30)

<i>Psychological Empowerment</i>	<i>Mean</i>	<i>S.D</i>
Meaning	13.3	2.77
Competence	12.15	2.99
Self-determination	11.85	2.83
Impact	10.3	3.11

Table 2. Mean and Standard Deviation of Female College Students on Big Five Personality Factors (N = 30).

<i>Personality Factors</i>	<i>MEAN</i>	<i>STANDARD DEVIATION</i>
Neuroticism	22.65	8.56
Extroversion	30.05	8.60
Openness	29.6	7.30
Agreeableness	27.1	7.22
Conscientiousness	28.35	7.13

Table 3: Coefficients of correlation between Psychological Empowerment components and Big Five Personality Factors.

<i>Variables</i>	<i>Meaning</i>	<i>Competence</i>	<i>Self determination</i>	<i>Impact</i>
Neuroticism	0.52 **	0.3790 **	0.22824	0.21388
Extroversion	0.69 **	0.5245 **	0.4580 **	0.39373 **
Openness	0.31 **	0.20239	0.30197 **	0.01480
Agreeableness	0.22	0.20107	0.17559	0.0407
Conscientiousness	0.35 **	0.06051	0.1871	0.634

** P < 0.05

From table 3 correlation analysis reveals that there is a significant positive relationship between big five factor and psychological empowerment. When we look at the table keenly it is understood that all dimensions are positively related to each other. Extraversion is significantly positive relationship with all dimension of psychological empowerment. Agreeableness on the other hand is not significant relationship with psychological empowerment. Neuroticism is significantly positively related with meaning and competence. Openness trait is positively and significantly related with the dimension meaning and self-determination. Conscientiousness is significantly and positively related with only one dimension of psychological empowerment i.e. meaning.

The present study aims at finding the relationship between big five personality factors and psychological empowerment among college going female students. On analyzing the table, it is seen that there is a positive correlation between big five personality factors and psychological empowerment. While neuroticism is characterized as fearfulness, irritability, low self-esteem, social anxiety, poor inhibitions of impulses and helplessness are positively and significantly correlated to the factors of psychological empowerment like meaning and competence and do not have any influence on self determination and impact. Neurotic individual may miss opportunities to see the meaning in their work and may see themselves as more incompetent than competent. But in current study the neurotic individual holds meaning to the work and feels they are competent to do any task.

Extraversion, is characterized as positive emotions, higher frequency and intensity of personal interaction, and higher need for stimulation, sociableness and sensation seeking behavior have a positive and significant relationship with all the factors of psychological empowerment. Extraversion trait contributes a lot to one's sense of meaning, his abilities and ambitions, autonomy as well as his virtue to make a difference (Spreitzer, 1997). Extraversion is, in general, associated with a tendency to be optimistic (Costa & McCrae, 1992). Psychological empowered individual are high in commitment and concentration (Kanter, 1983), persistent in challenging situation (Gecas, 1989), and high performance (Locke, et al 1984).

Openness trait has significant positive relationship with meaning and self-determination of psychological empowerment. Individual with openness trait are willing and ready to entertain and experience novelty (Costa & McCrae 1992), highly associated with the dimension of self-determination. Kitayama & Cohen (2010), described self-determination as an individual's control over the manner in which work is accomplished and is related to the choice cognition. Openness does not have significant relationship with the dimension competent and impact.

Agreeableness is the likeness of people to get along with others. How well one can be in a group with noticeable characteristic actually influences his competence and impact in a less positive way. The current study shows that there is no significant influence of the personality trait agreeableness on the function of psychological empowerment, i.e. there is no significant relationship between agreeableness personality trait and psychological empowerment. Conscientiousness is the degree to which the person is ambitious, organized and how far he can execute things as planned and get satisfied. It is one's will to do things and achieve it. It has significantly positive correlation with meaning but has no influence on one's abilities, determination and impact.

From the analysis of the results, it is seen that only extraversion has a positive significant relationship with all the factors of psychological empowerment and agreeableness has no influence on any of the psychological empowerment factors. Out of the four factors of psychological empowerment, only sense of meaning is influenced by most of the personality traits. Impact is the least influenced by any personality factors except for extraversion. Personality traits play a big role in perceiving things in life which enhances psychological empowerment. On addressing the results as a whole all the big five factors are positively correlated with factors of psychological empowerment. The study says that the big five factors has influence on one's perceptions and not much on one's actions.

This study has its own limitation. First and foremost one is that the sample size is small and it has limited power of generalization. In the present study correlation analysis computed, which does not explain the cause and effect relationship. Although, it has its own limitation the present can't be ignored because

it throw light on big five personality factors and psychological empowerment. Suggestion for further research is that the sample size could be increased, gender variance and demographical variable could be added.

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A 'MID-LIFE CRISIS' STUCK IN THE EMOTIONAL PAST: AN EXPLORATIVE CASE STUDY

Anoop Kumar K V * and T. Sasidharan**

ABSTRACT

An explorative case study research was undertaken to understand the dynamics of midlife crises in the Indian context. Few sample cases were selected using the method of judgment sampling, both males and females, between the age group 40 to 60 years. Methodology of case study was used for the research; aided with qualitative techniques for data collection. The individual case histories and life histories were subjected to qualitative thematic analysis to extract personal meanings and individual themes. . The individual case histories and life histories were subjected to qualitative thematic analysis to extract personal meanings and individual themes. Cases were selected on fulfilling the criteria of Mid-life crisis in the form of: being between 40 to 60 years of age, with either of whose parents are dead (assumption of adult role), married with at least one child above 5 years (assumption of adult role), exhibiting Subjective preoccupation with aging or objective signs of aging, expressing explicit or implicit symbolic ruminations of a better past, with no objective detrimental social or financial situation on analysis of the personal history, with initial satisfaction reported with the marital bond, receiving assessment and therapeutic intervention for minimum 20-25 sessions spanning over a period of at least 4 to 6 months. A typical case of guilt emanating from own lack of initiative in the past fueling a crisis at the confusing times of 'Middle-age' is presented here.

Keywords: Mid-life, Midlife crisis, Judgment sampling, Case study

Initiated by the Neo-Freudians who conceptualized it to be driven by "fear of impending death", the notion of Midlife crisis has led to the emergence of

* Ph.D. Scholar, Department of Psychology, University of Calicut.

** Reader, Department of Psychology, University of Calicut (This study was conducted under the Department of Psychology, University of Calicut, Kozhikode, Kerala in 2009-2015 as a part of PhD Work).

certain important theoretical constructs. Midlife has been referred to as the afternoon of life by Jung (1933) in his essay, "The Stages of Life". He points to the mental confusions that can occur in an individual's mind at this time period of life, describing it as a key to the process of self-awareness and self-actualization, leading to individuation.

Erikson (1963) held that people in middle- adulthood undergo a struggle to find new meaning and purpose to their own lives. First coined by Psychologist Jacques (1965) in an article entitled, "Death and midlife Crisis" it was theorized that the "Midlife crisis" was driven by a fear of impending death. Levinson (1969) proposed the Stage-Crisis view that deals with an individual's personality development. Accordingly in the middle adulthood the person must come to terms with following four major conflicts: being young versus old, being masculine versus feminine, being destructive versus constructive and being attracted to others versus being separated. Mid-Life Crisis was explained as a simple normative event in people's life by Levinson. A simple transitional event, that occurs in people's life at a given age.

Many subsequent studies have come up with opinions that negate the strictly stage crisis model and the universality of the whole concept. People who experience Midlife-Crisis are claimed to be a small group high in neuroticism, and the crisis itself is often considered a construct indefinable (Kruger, 1994). Although a strict definition of the midlife crisis does not seem tenable on empirical and theoretical grounds, a lenient conceptualization has the potential to stimulate new research directions (Freund & Ritter, 2009).

McAdams's 'life story model of identity' has been an important development in the context of narrative approaches to understand human behavior and experience. It asserts that people construct an internalized and evolving narrative of the 'self'. A life story reflects a number of important themes in developmental, cognitive, personality, and cultural psychology. An upsurge in interest has been witnessed among theorists and researchers in recent years in autobiographical recollections, life stories, and narratives (McAdams, 2001).

The concept of mid-life crisis entails all the intra-psychic ingredients and enough overt and formidable behavioral manifestations, to stimulate a multitude of academic research in the field of psychology. Unfortunately serious research endeavors are found lacking in the recent times in the international arena. The research gap in this area has been even more conspicuous in the Indian context. Even in the study of lifespan development in psychology, the lack of relevant and sufficient literature on the topic of mid-life, in itself is an idea worth an assumption. This explorative case study research was undertaken to understand the dynamics of midlife crises in the Indian context. A typical case of guilt emanating from own lack of initiative in the past, fueling a 'Crisis' at the confusing times of 'Mid-life' is being presented here through this explorative case study.

Case Study

Demographic details: Name of the client is SJT, a male 43 years of age, hailing from an upper-middle class socio-economic background. He is a Hindu by belief and is a chartered accountant by profession. He is married and is a father of two children: 12 year old girl and a 8 year old boy. His spouse is a 39 years old High School teacher working for the education department of the government. They live in an urban township and as a nuclear family.

Presenting Complaints

- Not able to get enough sleep at night (for past 2 years intermittently).
- Not able to keep-up a cheer full mood (some time around, after the birth of the second kid. Symptom is fleeting in nature).

Psycho-social History: The client hails from a traditional Hindu joint family and is a middle order child among 6 siblings. He shared normal relationship with his family with no significant emotional trauma or major physical illnesses and no clinically discernable mental illness from childhood through adulthood. He reportedly was shy in childhood and used to interact less with people. His friendship pattern has been selective and according to himself, has been probably an introvert by nature. He has been an above average student throughout and during school days used to be in the good books of his teachers. He used to like to indulge in games and sports but due to his shy nature, never attempted any of those at school. He was quite happy to merge into the crowd and never attempted to assume leadership roles during school days or college life thereafter. The communication pattern at his home was quite need based, with no active effort to express neither affection nor reprimand. He reportedly was more close to his mother and communication with father was mainly need based and indirect, through the mother. With his siblings, he states sharing a normal relationship with slight extra closeness to his elder sister. His main leisure activity during those days, he recollected as being solitary play activities and daydreaming. He obtained around 70% marks in tenth standard and got admission in the commerce group in a government college at home town. He reported his basic nature as largely unaltered even during his college days.

Later he joined degree level education and during this phase of life he described himself being slightly more open to mingling with people. Though still he never had any extensive friend circle, he maintained a cordial and warm relationship with a selected group of friends whom he termed "like minded". He described that all of them used to share lot of experiences with him and he used to be considered as a good listener. He cited the real reason for this as, being devoid of any particularly interesting experiences in life that merited his narration. He felt he was largely accepted among his classmates and shared cordial and need based relationship with most of them. During the second year he reported that

for the first time in his life, he spoke to a girl in his class at his own initiative. Slowly they started developing a friendship. The girl according to him, was of a similar nature like his kind, which meant being reserved but helpful. Their friendship grew by the day and for the first time he recollected academic life turning beautiful. Initially their discussions mainly centered on academics and career. But with time, they started sharing lot of personal space and he reported feeling very comfortable in revealing his feelings and sharing his experiences openly with her. Slowly he started spending more and more time with her and their friendship grew into an affectionate relationship and then into a mutually shared love relationship by the end of third year. At the end of college days he suggested to her that they should get married sometime in the future and she reportedly readily accepted it. Their plan was to get employed as soon as possible and then present the matter at their respective homes. The girl, with in some months, got a job in a private firm in the city. Even though it took another one and a half years for him to get a job, he used to regularly visit her during this time and maintained a steady communication with her, over phone. Then he fetched a meager job in a private firm and he reports having lot of positive expectation about life during this time. After almost five years of knowing and understanding each other, both of them presented the matter at their respective homes. Though initially slightly reluctant, the girl's family with time became open to an exploration. But the client's family was dead against the whole issue, as the girl belonged to a much lower caste. Though he tried his level best to persuade them, he just could not succeed in convincing them. He recollected as lacking enough courage during those times to be assertive with his family, especially with his father. His family maintained it strict that, if he went against the family honor, then they would treat him like an outcast stranger. He had an elder sister also to be married off at that time and moreover for finance too he was totally depended on his family, as his meager salary did no afford him any luxury of living independently. The girl reportedly tried to give him strength to convince his family, but at last even she could not withstand the social pressure for marriage and was married off to someone else. He reported, that one year period following her marriage, as the hardest times he ever faced in life. He lacked any interest in life as everything he did appeared mechanical. He reported having no feeling of anger or revenge towards his family but recollected that he was just upset about his misfortune. In one year time he got an opportunity to be placed in the gulf with the help of an acquaintance and grabbed the opportunity happily. Primarily it was an effort to just escape from his immediate environment. He worked there for almost seven years and used to periodically visit his home. Slowly things turned normal and he developed a normalized emotional bond with his family too. He reportedly was very hard working and said that he could develop lot of accounting skill and interest and expertise in that field during the time. His financial

back-up vastly improved and he made a new reliable friendship there. Both of them decided to start a firm together and when they returned back after six years of being in gulf, they set up an accounting firm in the client's home town. The organization clicked and he reported never having to look back after that. He married at the age of thirty and the marriage was an arranged one with the full consent of his family. The girl was a higher secondary school teacher. He felt the woman fulfilled all his initial expectations and as life proceeded, she proved to be a perfect life mate. They got a baby girl in one year and in a couple of years his wife got permanently appointed in a government school at his hometown. By this time his firm has grown large enough and he parted cordially from the partnership and established individual business which evolved reasonably well. But even though he was financially sound and his wife was a perfect partner who had a permanent job and he was happily settled, he reports a feeling of insecurity haunting him most of the times; the reason of which he knew not what. So he insured his business. He took a couple of insurance policies in his name and his wife's name too. He reported being perfectly legal and law abiding in his business and avoided any chance of risk. After the birth of his second child he reported starting to feel a kind of boredom in life for which he found no reason neither solution. His professional life had been remarkably successful and his sexual and emotional relationship with his spouse was also reasonably well off. He has to bear some burden of his siblings who were not doing that reasonably well in life, but all those responsibilities were over by this period. Still he felt a kind of inadequate and thought that the prime reason was that, though he was an expert in the business he was not a qualified one. So at the age of 36 he enrolled for an accredited chartered accountancy course and in a period of 2 years completed it successfully. It added lot of legal strength to his business which as usual was flourishing reasonably. Still he felt he was just mechanical in life and there was no real happiness in things he does. During these times he started developing occasional sleeplessness at nights. His sleep usually got disrupted by dreams from which he could not discern any significant meanings. He faced difficulty in falling asleep too. This prompted him to go on an insurance spree. He reported that to date he has insured most of the things and people at home to such an extent that nothing if ever destroyed or stolen could be a matter of concern. But even after being a successful professional, having a happy settled family and enough safety precautions; he felt inadequate and in his own words 'robot like'. Over the past couple of years his sleeplessness has increased to such an extent that, the tiredness reflected on his face when he gets up in the morning. Tough it has not affected his work or relationship patterns in any way, according to him it is a source of irritating personal distress. One year back he consulted a psychiatrist for this problem and he was put on psycho tropics. Initially for a couple of months he stated as experiencing partial relief but later started developing

tolerance for the drug. Slowly the dose had increased but the effect was still on the decline. This prompted him to stop the medication after informing his doctor, who suggested that he may meet a psychologist who may be of help to him. Hence 6 months after stopping the medication and continuing with the symptoms of sleepiness and tiredness, he consulted the Clinical Psychologist.

Past History

- Organicity: Nil significant.
- Mental illness: Nil significant.
- Medical history: Nexito 0.5 mg 0-0-1 for 3-4 months with partial initial improvement un-sustained and discontinued for past 6 months, before this consultation.

Family History

- Mental illness: Nil significant.

Diagnosis

- Insomnia (mild to moderate) and fleeting in nature
- Dysthymia mild (general lack of well-being)

Treatment Framework: Starting with Client centered approach in the initial phase and slowly merging into Brief Dynamic work to facilitate insight into the symptoms.

Therapy sessions: The initial part of the therapy sessions were devoted to take a detailed case history and just to allow him to be acquainted and get comfortable with the therapist. Over a period it was found that some of his dreams as viewed in the Dynamic framework could be roads to his unconscious. He was asked to record some of his dreams and it was analyzed for its latent content.

A particular dream which repeatedly occurred is worth mentioning here for the peculiarity of its content:

"In this particular dream he reported been getting ready for office. On the dressing table gazing at the mirror he felt very uncomfortable and panicky. Then the next scene he remembers is being arrested by the police. He tries to convince them of his innocence but then suddenly he slips off into something like dirt or the like, and his sleep gets disrupted. After a while he sleeps off and continues to dream in patches something connected to the theme but does not remember anything about it, though many a times he dreamed the same theme."

It was assumed from analysis of the theme of the dream that, both in his conscious and unconscious mind, one common island of insecurity exists. Till this point in therapy he had not expressed any ideas of guilt or remorse about any wrong doings of which he is consciously aware of. But there was one instance which he justified through intellectual reasoning; his inability to act out his will. That is his love story. He never blamed his father or family or society for his

heart break. Not even implicitly. Till that point in his story (history) he had narrated in great detail the feelings he and his former girlfriend went through. But after the break up episode he has summarized the whole process of readjustment in just a couple of lines and proceeded directly to a detailed description about the success of his business life and life thereafter. It seemed like there was some unfinished emotional ventilation with his father, who is no more. It could also be with his family or other social factors, which restricted him at that time. May be the expression of his pent up past feelings even in the present, appeared to be guilt inducing. It was becoming clear that the 'police' was a revisit from the past, of the authority figure or figures, and the fall was a regression into the passive-shell of his past inability to assert. The analytic question that remained was, what guilt inducing thought or action of the present invited this buried past into current play. Next couple of sessions, the client missed, according to him due to certain unforeseen engagements. The revelation came through in the later couple of sessions, in the form of his confession that, he still at times longs for his past relationship. He said his wife is good and perfect; physically, mentally and socially. She is a good mother and a great wife. She cares for him but somehow he doesn't get cared. Means over the past few years he feels he is lacking something and he 'needs to change'. Then he immediately corrected it saying, "I mean I need to sleep better again".

Probably the period was nearing in the therapy to reflect the therapist's interpretations to the client. The next session he again missed and it was rescheduled. He called up again on the rescheduled date to express his inability to make it on that day too, but said he wanted to refer a staff from his office that seemed to suffer from some kind of social anxiety. He sought permission to pass on the therapist's phone number to him. As to the next appointment he said he would call up and fix it up very soon, as for then it was the month of March and he was caught in the audit. That was the final communication and no further session materialized.

Outcome of intervention: Partial clearance of presenting complaints

Transpiring mental processes: The working impression formed soon after the history taking was that of "dysthymia" with "insomnia". Symptomatically speaking, after this amount of brief dynamic work with the client, it is clear that the first diagnosis doesn't stand but the second one stands firm. But then one thing was clear; the person is longing for a change. He had a serious wish to relive the past. He perceives his present as flawless but flashes from the memories of an earlier romance disturbs him. It's noteworthy that his age range perfectly falls into the transition phase of human life called the 'Mid-life'. Certainly this appears to be a case of "Midlife-crisis" with a tint of guilt feeling arising from his past leading to the fleeting condition of Insomnia. A classic case of guilt emanating from own lack of initiative in the past, resulting in present rumination

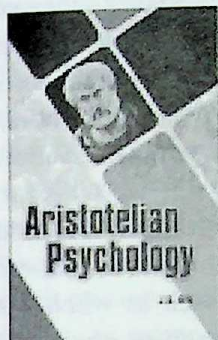
about an incomplete past relationship. This conflict is forcing its expression through the brittle state of the confused mindset at mid-life.

Insight from the case study: With the onset of a midlife crisis there transpires a plodding perception of lack of joy (vitality and contentment) in usual mundane life activities which hitherto appeared purposeful and gratifying. This loss of pleasure leads to a meta-cognitive dilemma involving an evaluative self-review. Discernment of an existential meaninglessness arouses a state of negative emotion and feeling in the individual. This subtle mood change brings about a gradual but sweeping change in the pattern of interpersonal relationship resulting in distortions and imbalances. The ability to derive fun and enjoyment from any activity, person or matter with in the usual circumstances, almost entirely wanes. Such a state of mental affair on progressive accumulation results in significant dissatisfaction in socio-emotional, professional and routine functioning of the individual. In its extreme it can culminate in development of neuroticism.

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BOOK REVIEW



Aristotelian Psychology

By J.S. Bill

Global Vision Publishing House, New Delhi,

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2016 (Edition: 2nd)

The power of thought (cognitive psychology of today) that distinguishes the human soul from the other creatures was identified by Aristotle in nearly 335-323 B.C. The very original work done by Great Aristotle which was teleological, philosophical, metaphysical and physiological in nature was clearly, simply and beautifully explained in this book by the learned author, J.S. Bill. The author explained the work of Aristotle in psychological area without destroying the essence of it in a very simple manner, and it is very much creditable. Although it is very hard to review the book which is on the work of Great Aristotle and the author did it wonderfully even though I did it with humble apology for any mistake in reviewing it.

The book has seven chapters. Chapter-1 starts with a very brief life history of Aristotle and concentrates on the two basic problems of Psychology—the unity of person and the relation between the person and the rest of the world with the key word 'THOUGHT'. The chapter focuses on Aristotle's psychological writings which reveals more theoretical, more self-conscious about method and more alert to general philosophical questions about perception, thinking and soul-body relations and at the same time claims that the soul is the first actuality of a natural organic body which has life in potentiality. This claim is applicable to plants, animals and humans alike. Aristotle defines the imagination as "the movement which results upon an actual sensation." In other words, it is the process by which an impression of the senses is pictured and retained before the mind, and is accordingly the basis of memory. The representative pictures which it provides

form the materials of reason. Illusions and dreams are both alike due to an excitement in the organ of sense similar to that which would be caused by the actual presence of the sensible phenomenon. Memory is defined as the permanent possession of the sensuous picture as a copy which represents the object of which it is a picture.

Chapter -2 explains Phenomenology of psyche i.e. Philosophical study of the structures of experience and consciousness about soul. In fact, it is not a doctrine, nor a philosophical school, but rather a style of thought, a method. Sense perception is a faculty of receiving the forms of outward objects independently of the matter of which they are composed. As the subject of impression, perception involves a movement and a kind of qualitative change; but perception is not merely a passive or receptive affection. It in turn acts, and, *distinguishing* between the qualities of outward things, becomes "a movement of the soul through the medium of the body." The objects of the senses may be either (1) special, (such as color is the special object of sight, and sound of hearing), (2) common, or apprehended by several senses in combination (such as motion or figure), or (3) incidental or inferential (such as when from the immediate sensation of white we come to know a person or *object* which is white). There are five special senses. Of these, touch is the rudimentary, hearing the most instructive, and sight the most ennobling. The organ in these senses never acts directly, but is affected by some medium such as air. Even touch, which seems to act by actual contact, probably involves some vehicle of communication. For Aristotle, the heart is the common or central sense organ. It recognizes the common qualities which are involved in all particular objects of sensation. It is, first, the sense which brings us a consciousness of sensation. Secondly, in one act before the mind, it holds up the objects of our knowledge and enables us to distinguish between the reports of different senses.

Chapter-3 deals with psycho-physical analysis of ontological materialism. The identity theory of mind holds that states and processes of the mind are identical to states and processes of the brain. Strictly speaking, it need not hold that the mind is identical to the brain. The identity theory of mind is to the effect that experiences just *are* brain processes, not merely *correlated with* brain processes. His concern is with the "principle of motion" of living entities. He distinguishes three types of soul : Nutritive, Sensory, Thinking. Most of Aristotle's discussion of the soul is "naturalistic"—that is, it appears to only describe entities whose existence is already countenanced in the natural sciences (primarily, physics). This is especially brought out by his claim that the soul seems to be the form of the organism.

Chapter-4 gives information about Sensation, imagination and thinking. Sensation is the passive capacity for the soul to be changed through the contact of the associated body with external objects. In each variety of sensation, the

normal operations of the appropriate organ of sense result in the soul's becoming potentially what the object is in actuality. Thus, without any necessary exchange of matter, the soul takes on the form of the object: when I feel the point of a pin, its shape makes an impression on my finger, conveying this form to my sensitive soul (resulting in information). Thought is the more active process of engaging in the manipulation of forms without any contact with external objects at all. Thus, thinking is potentially independent of the objects of thought, from which it abstracts the form alone. Even the imagination, according to Aristotle, involves the operation of the common sense without stimulation by the sensory organs of the body. Hence, although all knowledge must begin with information acquired through the senses, its results are achieved by rational means. Transcending the sensory preoccupation with particulars, the soul employs the formal methods of logic to cognize the relationships among abstract forms. Desire is the origin of movement toward some goal. Every animate being, to some degree, is capable of responding to its own internal states and those of its external environment in such a way as to alleviate the felt absence or lack of some pleasure or the felt presence of some pain. Even actions taken as a result of intellectual deliberation, is supposed to produce motion only through the collateral evocation of a concrete desire. As the father of the field of logic, he is the first to develop a formalized system for reasoning. Aristotle observed that the validity of any argument can be determined by its structure rather than its content. Aristotle's emphasis on good reasoning combined with his belief in the scientific method forms the backdrop for most of his work. Aristotle distinguishes sense perception from reason, which unifies and interprets the sense perceptions and is the source of all knowledge. Aristotle assumed that the structure of language and logic naturally mirrors the way things really are.

Chapter-5 explains theory of action and rationality in terms of teleology. So far from offering a decision procedure, Aristotle insists that this is something that no ethical theory can do. His theory elucidates the nature of virtue, but what must be done on any particular occasion by a virtuous agent depends on the circumstances, and these vary so much from one occasion to another that there is no possibility of stating a series of rules, however complicated, that collectively solve every practical problem. The intermediate point that the good person tries to find is "determined by *logos* ('reason,' 'account') and in the way that the person of practical reason would determine it" To say that such a person "sees" what to do is simply a way of registering the point that the good person's reasoning does succeed in discovering what is best in each situation. Aristotle's point of view on practically wise, encratic and the acratia features like motivational impact on pleasure/ pain balance, physical impact of deviant desires and theory of rationality. Although the study of virtue (theory of rationality) Aristotle has just completed, is meant to be helpful to all human beings who have been brought

up well—even those who have no intention of pursuing a political career—it is also designed to serve a larger purpose. Human beings cannot achieve happiness, or even something that approximates happiness, unless they live in communities that foster good habits and provide the basic equipment of a well-lived life. The study of the human good has therefore led to two conclusions: The best life is not to be found in the practice of politics. But the well being of whole communities depends on the willingness of some to lead a second-best life—a life devoted to the study and practice of the art of politics, and to the expression of those qualities of thought and passion that exhibit our rational self-mastery

Chapter-6 explains Aristotle's theory of the emotions was neither the mere preliminaries to developing such a theory, nor a theory appropriated from a predecessor such as Plato. In his theory, to have an emotion is to experience pain, pleasure or both, where this pain or pleasure is intentional and representational. An emotion is pain or pleasure at the emotion's object, where that object is represented in ways that give grounds for the particular emotion experienced. Aristotle's development of this view had some limitations, but the view itself seems to have considerable merits. Aristotle's preferred term for the emotions was *pathos* [pl. *pathe*], which makes the emotions largely passive states, located within a general metaphysical landscape contrasting active and passive, form and matter, and actuality and potentiality. The *pathe* are not pure potentialities. They are actualized in the experience of an occurrent emotion, and even the mere capacity to experience *pathe* requires a determinate form, a soul. Moreover, the *pathe* have close connections to action, and Aristotle treats them as movements of a sort. For all these reasons, the *pathe* can be attributed to the soul insofar as the soul informs a body. Yet since their causes lie outside of the animal who experiences them, the question arises whether and to what extent we can control them. The *pathe* are not themselves virtues or vices. But states are, and that means that the *pathe* are morally significant. More generally, because emotional experience is intrinsic to any life, any account of the good life must give them their due. Aristotle took the excellence of the excellent human to consist partly in experiencing *pathe* in the right way, to the right extent, and on the right occasions. Indeed, the cultivation of character is largely a matter of cultivating the disposition for appropriate experience of the *pathe*, which is as important as developing our abilities for deliberative reason. The appropriate emotional dispositions may, in fact, be even more crucial to the good life, since our capacity to feel the passions seems intrinsic, while our ability to reason develops with maturity and can be crucially affected by our emotional dispositions. In any case, the truly excellent person will not only reason well about what to do in particular situations, but will feel the appropriate desires and *pathe* in those situations. For this reason, the intellectual virtue for deliberating about what to do, *phronesis*, is distinguished from the other practical intellectual virtues of *techne* in part by its involvement with *pathe*.

Book Review

The chapter -7 gives Aristotle's psychology which includes a study into the formation of the human mind, as one of the first salvos in the debate between nature and nurture that influences many academic disciplines, including psychology, sociology, education, politics and human geography. Aristotle is a believer in nurture, stating that the human mind is blank at birth and that educating the individual and exposing them to experiences would define the formation of the mind and build a store of knowledge

The book summaries Aristotle's work as simple as possible and in doing this there is repetition of concept's descriptions might be all the basic concepts are interlinked. I congratulate the author for doing this remarkable work with my best wishes.

Dr. Rekha Sharma,

Associate Professor in Psychology

Government National College, Sirsa (Haryana)

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Nov Rattan Sharma is working as professor of Psychology at M. D. University, Rohtak (Haryana). With a teaching and research experience of more than 32 years, Professor Sharma has contributed 132 research articles to various journals and books of international repute.

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Nov Rattan Sharma is working as professor of Psychology at M. D. University, Rohtak (Haryana). With a teaching and research experience of more than 32 years, Professor Sharma has contributed 132 research articles to various journals and books of international repute.

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